

September, 1958

Canadian Hospital

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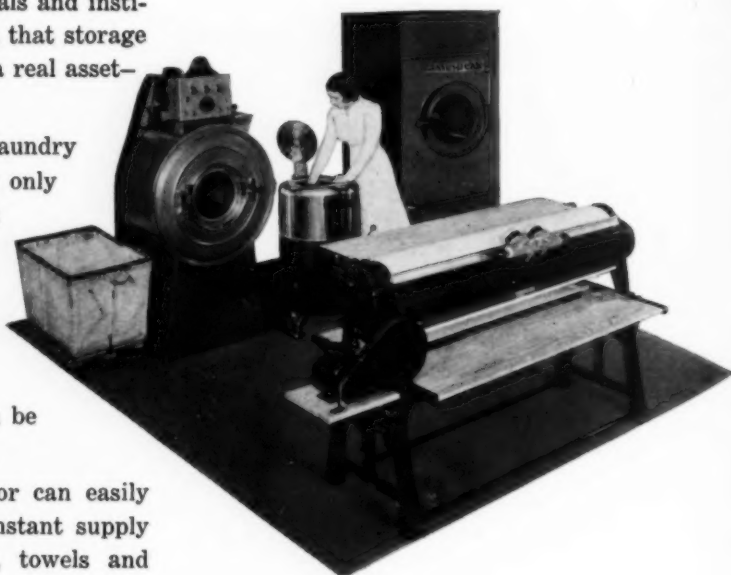
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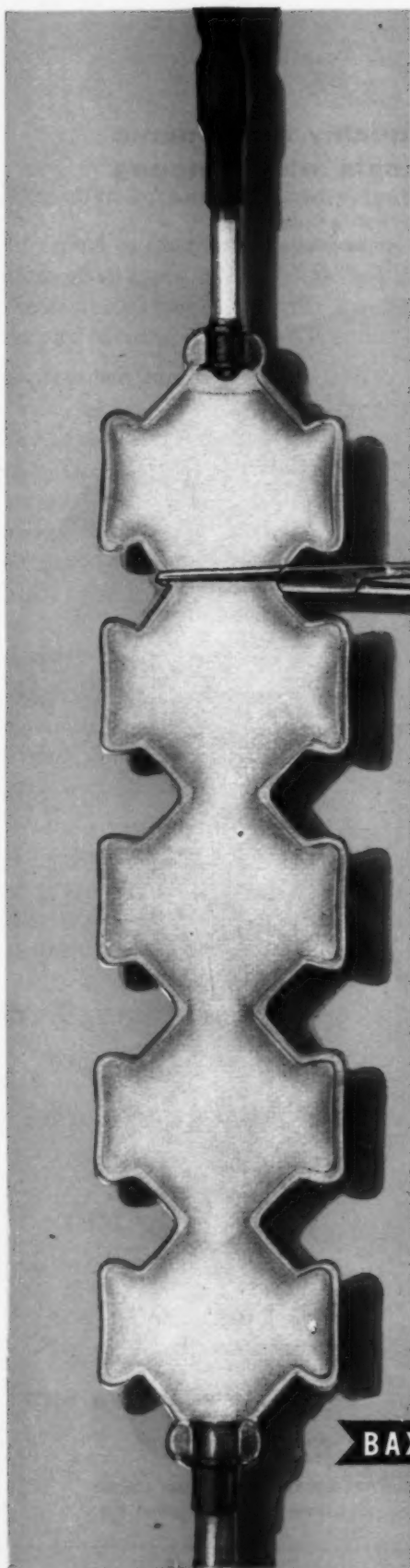


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Canadian Hospital

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Contents

September, 1958, Volume 35, No. 9

Notes About People	12
Obiter Dicta	33
Historique de Ste-Justine	35
<i>Mme L. de G. Beaubien</i>	
A brief tour of the new Sainte Justine	37
<i>Sr. Noemi de Montfort</i>	
The Architectural Point of View	42
<i>Joseph Sawyer, A.A.P.Q. and Henri S. Labelle, F.R.A.I.C.</i>	
Preparing to Move	44
<i>Gaspard Massue</i>	
Nursing Service and School	45
<i>Sr. Laurette</i>	
Medico-Social Service	46
<i>Gaston Lapierre, M.D.</i>	
Rehabilitation Services	48
Emergency Department	51
<i>Edmond Dubé, M.D.</i>	
A Premature Centre	53
<i>Robert Saint-Martin, M.D.</i>	
La Physiologie Cardio-Pulmonaire	55
<i>Emilien Labelle, M.D.</i>	
Psychiatric Services	62
<i>Denis Lazure, M.D.</i>	
Le Service Alimentaire	66
<i>Sr. Claire du S. Sacrement, B.Sc. N.</i>	
Physiotherapists in Canada—Part II	76
<i>Helen M. Gault</i>	
How to Avoid Medico-Legal Problems—Part III	82
<i>Frederick Evis, M.D.</i>	
Mind Over Matter—Conclusion	84
<i>David Lander, M.D.</i>	
Provincial Notes	90
C.S.R.T. Convention	94
<i>L. J. Cartwright, R.T.</i>	
With the Auxiliaries	110
Twenty Years Ago	126
Coming Conventions	129
Classified Advertising	130
Across the Desk	134
Index to Advertisers	140

(For Subscription Rates see page 118)

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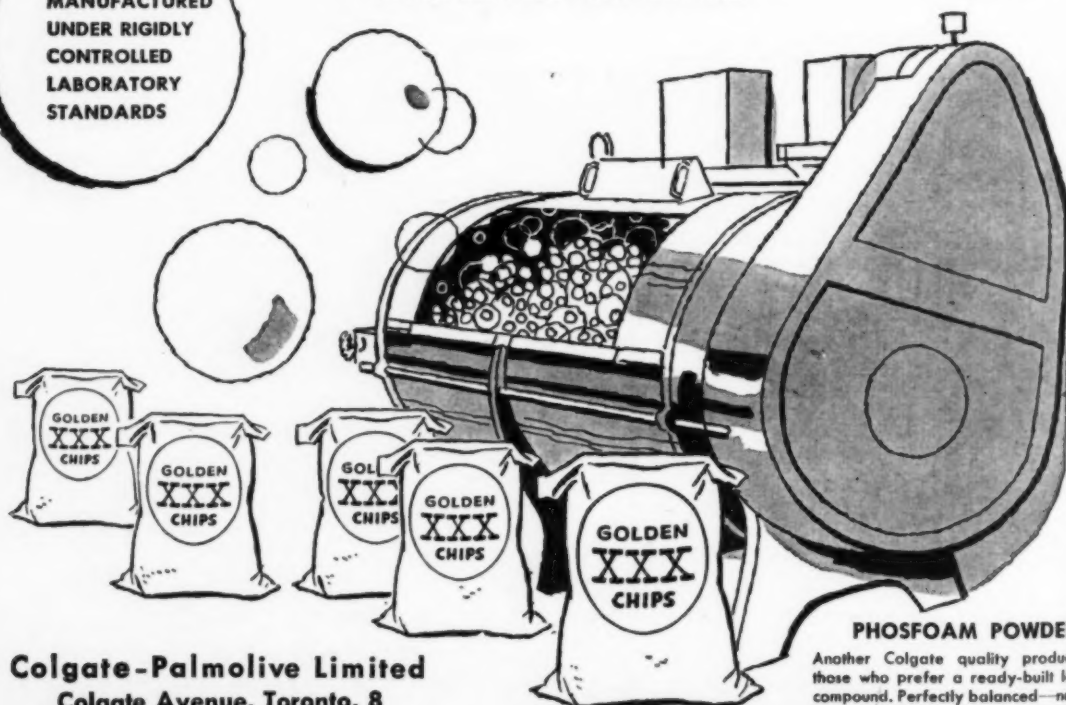
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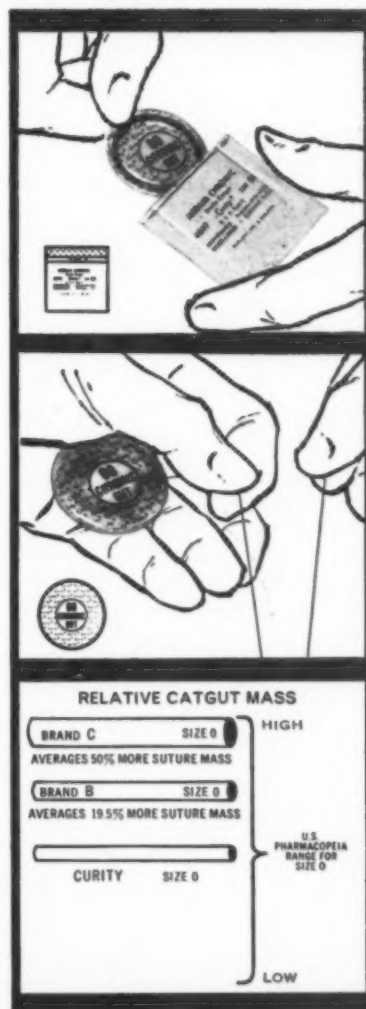
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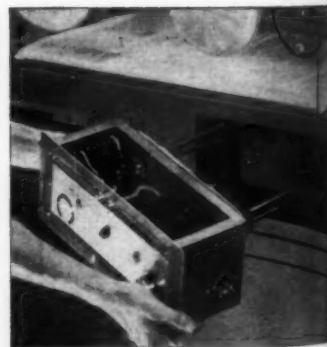


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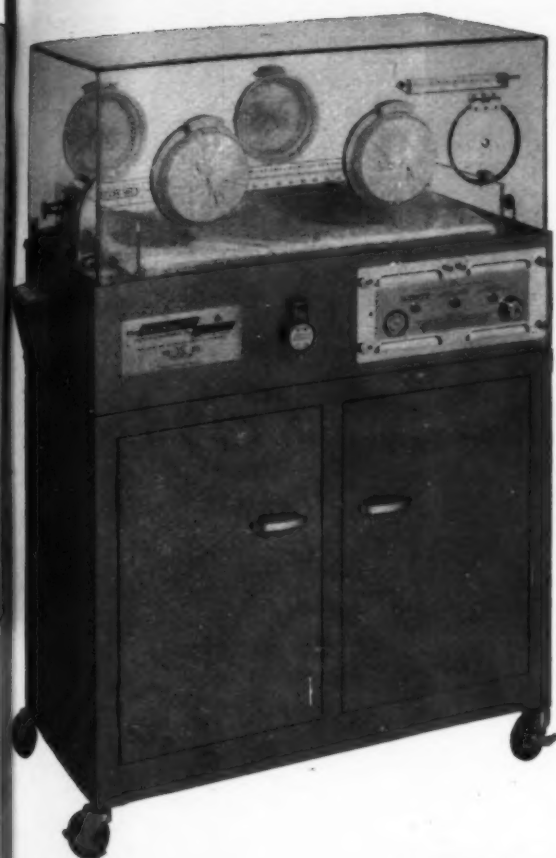
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*Zinsser, H.: Bacteriology, ed. 11, New York, D. Appleton-Century Co., Inc. 1957, p. 244.

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◀ Notes About People ▶

Appointment at the W.C.B., Toronto

B. H. G. Curry, M.D., recently appointed medical director of the Hospital and Rehabilitation Centre, Toronto, is a native of Manitoba and a graduate of the University of Manitoba's medical school in 1937. Dr. Curry took two years post-graduate training and then spent six years in the Royal Canadian Army Medical Corps—in field units and in hospitals.

Two years of post-war training in orthopaedic surgery in the Christie Street Veteran's Hospital was followed by one year in plastic surgery. Then Dr. Curry spent one year as resident orthopaedic and plastic surgeon in Vancouver and one year on the surgical resident staff at the Hospital for Sick Children in Toronto.



B. H. G. Curry, M.D.

In 1949 he became a fellow in the Royal College of Physicians and Surgeons of Canada; in 1950 he joined the staff of the Workmen's Compensation Board as surgical specialist. Three years later he was made chief medical officer. He remained in this post until he became co-ordinator of rehabilitation and treatment services in September 1956. In July of this year, he took on his present position.

Also at the W.C.B.

Born and educated in Toronto,

William R. Kerr joined the staff of the Workmen's Compensation Board in 1940. During World War II, he served overseas with the R.C.A.F.

Mr. Kerr held supervisory positions for many years. He became interested in the board's relations with employees, employers and the medical profession. Early in 1953, he was appointed medical aid officer—a liaison between the board and the various medical groups who provide services.

In 1955, he became chairman of the public relations committee, and in April of the same year, he was made director of public service. His latest appointment, effective last month, is to the post of administrator at the Hospital and Rehabilitation Centre.

Anna Marion Hilliard

Dr. Marion Hilliard, Toronto, Ontario, died on July 15 at the Women's College Hospital. She was 56 years of age.

Dr. Hilliard came to Victoria College and the University of Toronto's school of medicine from Morrisburg, Ont., and graduated in 1927. She did post graduate work in Budapest and Vienna, and studied obstetrics in London, England, and Ireland.

She joined the staff of the Women's College Hospital as assistant to Dr. Marion Kerr, and succeeded her as chief of obstetrics and gynaecology in 1947. In 1957 Dr. Hilliard retired from this post. During her 27 years on the staff of Women's College, Dr. Hilliard did much to help the hospital to grow physically and in reputation. Under her guidance as chief of obstetrics there, that department achieved teaching status by becoming associated with the University of Toronto's faculty of medicine in 1955.

She also headed the hospital's building campaign committee in 1952 which raised \$50,000 for a new addition. A fund begun by appreciative patients of Dr. Hilliard helped, too, and it was to this fund that Dr. Hilliard gave the proceeds from her book, "A Woman Doctor Looks at Love and Life."

Changes at Saskatoon

The University Hospital, Saskatoon, Sask., has a new chief accountant. E. L. Dick assumes the position this month, taking over from E. L. Casey who has gone to the Winnipeg General Hospital as controller.

Mr. Dick graduated in arts and commerce from the University of Saskatchewan in 1951, and from the C.H.A. course in Hospital Organization and Management in 1958. He has been assistant chief accountant at the University Hospital since 1954. Mr. Casey received his Bachelor of Commerce degree at the University of Saskatchewan in 1947, and completed studies for his Master's degree in hospital administration at Northwestern University in 1954. He joined the staff of the University Hospital as chief accountant in April of that year—he was one of the hospital's first employees.

Elsbeth F. Moir Retires

After many years of service, Elsbeth F. Moir retired from her position as assistant secretary of the Ontario Hospital Association in June.

Before joining the O.H.A. staff in 1948, Miss Moir was private secretary to the national commissioner of the Canadian Red Cross Society, the late Dr. Fred W. Routley who was also the executive secretary of the association. She, therefore, even before 1948, became more and more involved in O.H.A. activities.

At the time she came on staff of the O.H.A., the annual conventions of the association were becoming increasingly important, with each year showing a significant increase in the numbers attending and exhibitors participating. Miss Moir played a major rôle in developing the organization of the conventions with their innumerable details into a smoothly running system.

This in itself was an achievement but it occupied only part of her time. Miss Moir recorded the transactions of board and other committee meetings in a manner that provides a comprehensive history of the association for many years back. These are only the highlights of a career devoted to two organizations which are dedicated to service to others, the Red Cross and the O.H.A.

At Montreal Children's Hospital

Dr. Robert Ingram became executive director of Montreal Children's Hospital.

(Continued on page 18)



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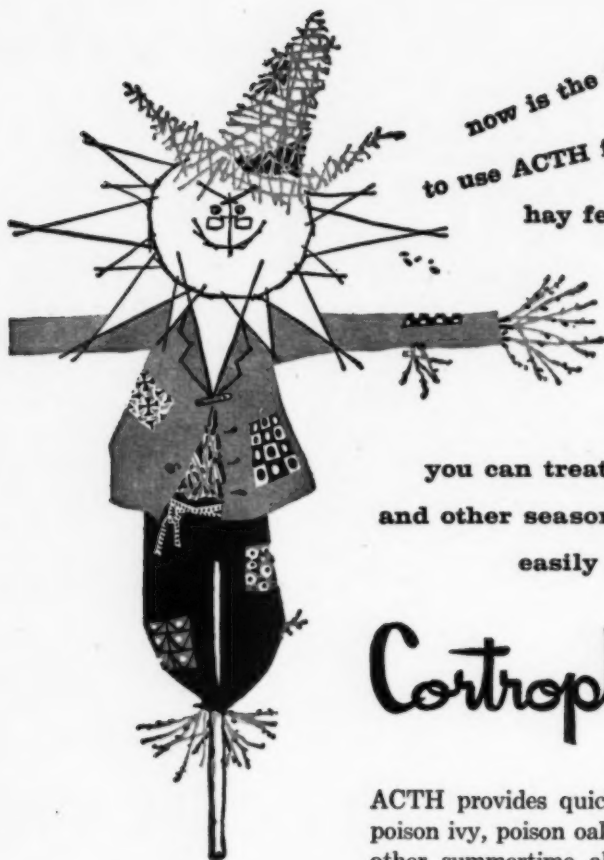
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1. Alexander, Edythe L.: Mod. Hosp., May, 1957

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People

(Continued from page 12)

ren's Hospital in June, succeeding Dr. John E. deBelle who retired. A graduate of the University of Toronto's course in hospital ad-



Robert Ingram, M.D.

ministration, Dr. Ingram completed his internship at Royal Victoria

Hospital, Montreal, and joined the staff as administrative assistant in 1956, remaining there until his present appointment.

Dr. deBelle, too, came to the Montreal Children's Hospital after administrative experience at the Royal Victoria, in 1937. Except for a period of service with the Royal Canadian Navy (1941-45) from which he was discharged with the rank of Surgeon Commander, he served the hospital until his retirement this year. His ability as an administrator and his excellent community relationships were responsible for a marked improvement in the hospital's financial position. The opening of the new 400-bed building in 1956, with its modern facilities for the study, treatment, and prevention of diseases in infants and children, was to him as to all concerned the fulfilment of a long cherished dream. Dr. deBelle is a fellow of the American College of Hospital Administrators. He has long been active in the work of the Montreal Hospital Council as well as several provincial organizations which are concerned with the welfare of crippled children.



John E. deBelle, M.D.

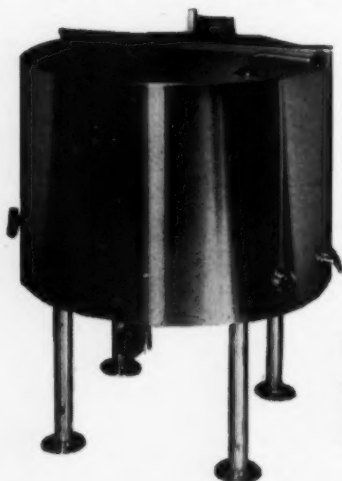
Graham L. Davis

Graham L. Davis, well known to many Canadians during his years as director of the hospitals division, W. K. Kellogg Foundation, died recently from injuries received in an automobile accident. A former head of the Duke Endowment in the Carolinas, Mr.

(Concluded on page 24)

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People

(Concluded from page 18)

Davis was deeply interested in the development of rural hospital facilities and he laid the groundwork for a national survey by the Commission on Hospital Care. In Canada, Mr. Davis made survey studies in Manitoba and in British Columbia and was a frequent speaker at hospital association meetings. He was a past president of the American Hospital Association and an honorary fellow of the American College of Hospital Administrators. Last year Mr. Davis, who was 65, came out of retirement to assume the position of administrator at Onslow Memorial Hospital, Jacksonville, N.C.

- The newly-appointed director of nurses at Tillsonburg District Memorial Hospital, Tillsonburg, Ont., is Mabel Johnson, R.N. Mrs. Johnson came to this hospital a year ago as assistant to the former director, M. E. Wood.

- Dr. Paul Desautels has been made medical director at l'Hôtel-Dieu de Gaspé, Gaspé, Que. Originally from Adams, Mass., Dr.

Desautels studied medicine at Laval University.

- A new assistant pathologist has been appointed at the Jewish General Hospital in Montreal. He is Dr. W. Arthur Harland, a native of Belfast, Northern Ireland, and a graduate of Queen's University of Belfast. His post graduate training was completed in the United States. Dr. Harland has been pathologist and director of laboratories at St. Joseph's Hospital, Chatham, Ont., since 1955.

- Gladys Lehigh, R.N. has been appointed superintendent at Prince Edward County Hospital, Picton, Ont. She succeeds Aileen Arnold who recently resigned.

- Frank H. Silversides is leaving the position of hospital management consultant for the Department of Health and Welfare, Ottawa, Ont., to take up the office of administrator at Cornwall General Hospital, Cornwall, Ont. The position has been created because of the resignation of former superintendent, Martha E. Nephew. A director of nurses, to be appointed

later, will take over the supervision of patient care and the nursing staff.

- M. Philip Garfinkle, a member of the board of administration at the Jewish General Hospital, Montreal, Que., since 1947, has been made president of the board. He succeeds David Kirsch who retired after holding the position for three years.

- Dr. John C. Wong, formerly assistant administrator at the Winnipeg General Hospital, Winnipeg, Man., has been made assistant administrator of the privately-owned Doctors' Hospital in Toronto. Dr. Wong graduated in medicine from the University of Singapore, and studied hospital administration at Yale.

In Error

Through a misunderstanding, the report of the C.S.L.T. convention appeared in the August issue under the authorship of Ileen Kemp, rather than William Mulligan of Niagara Falls, Ont. Our apologies to Mr. Mulligan.

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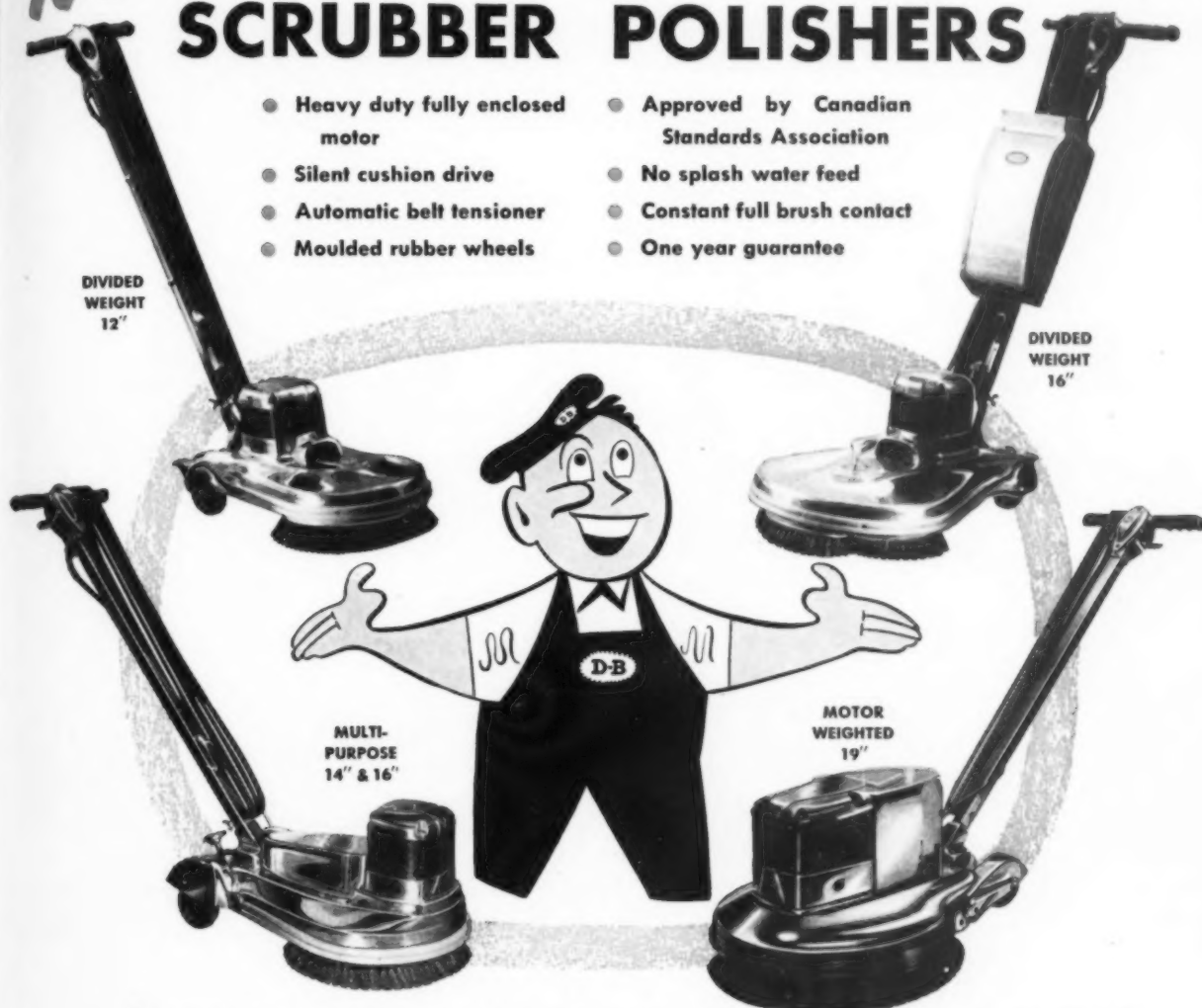


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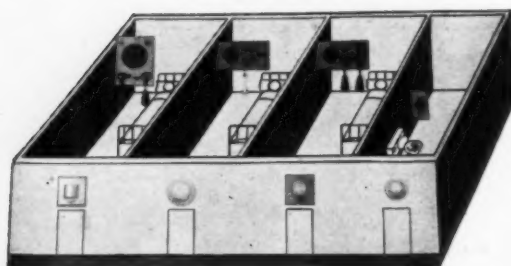
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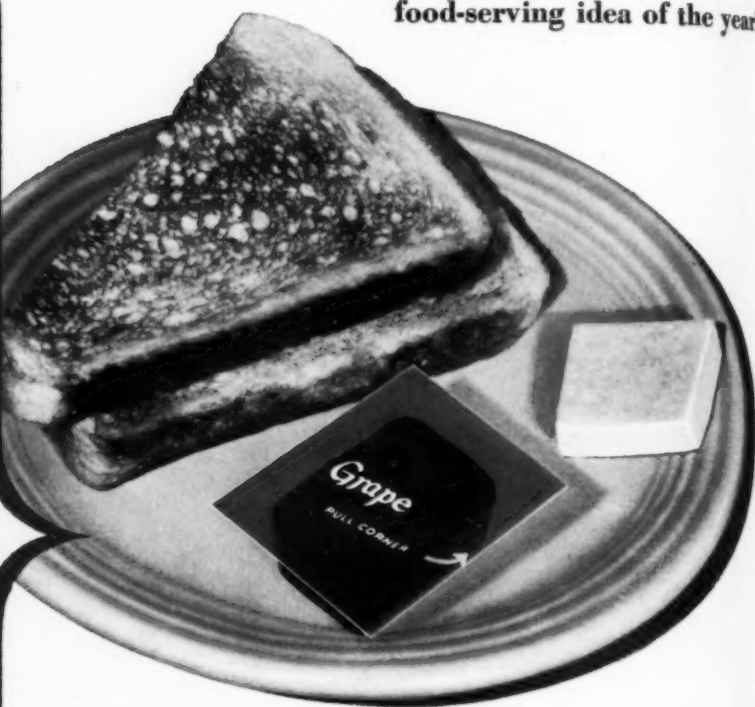


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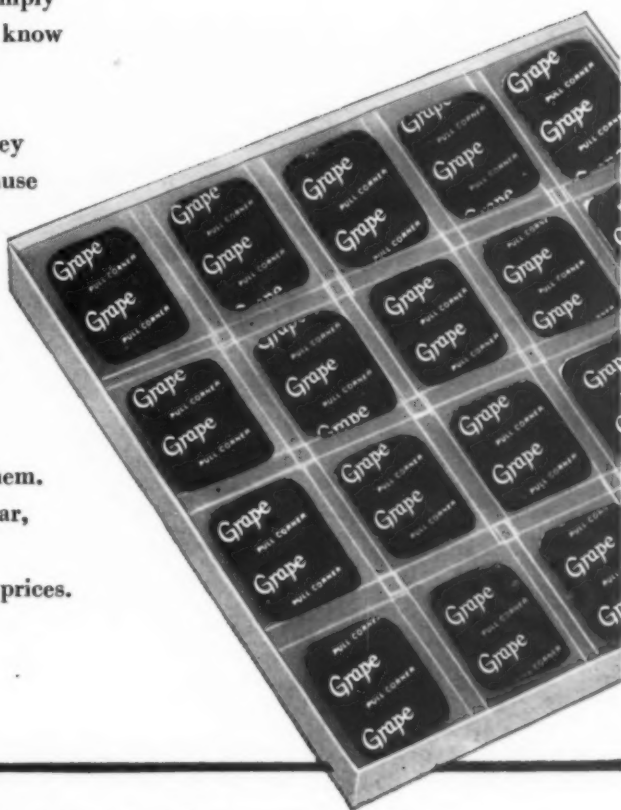
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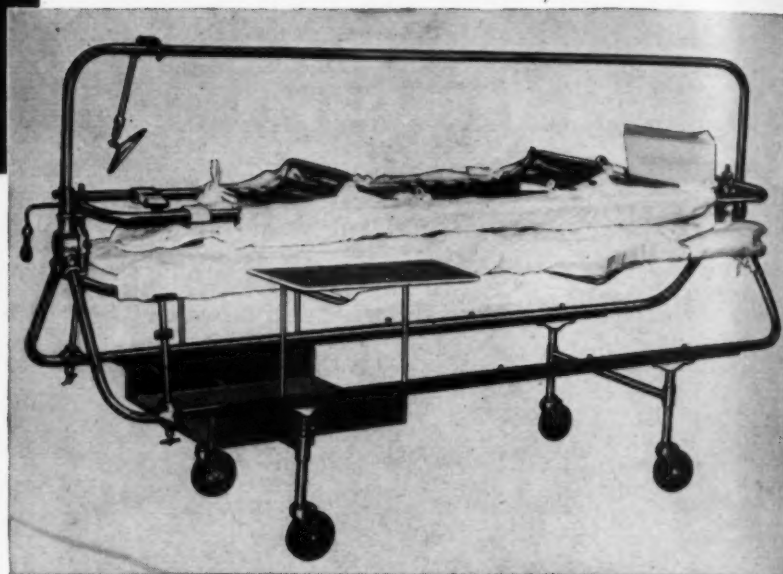
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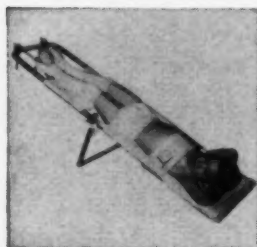
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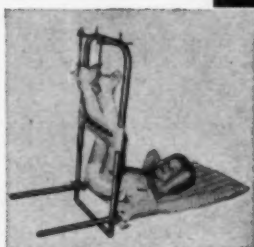


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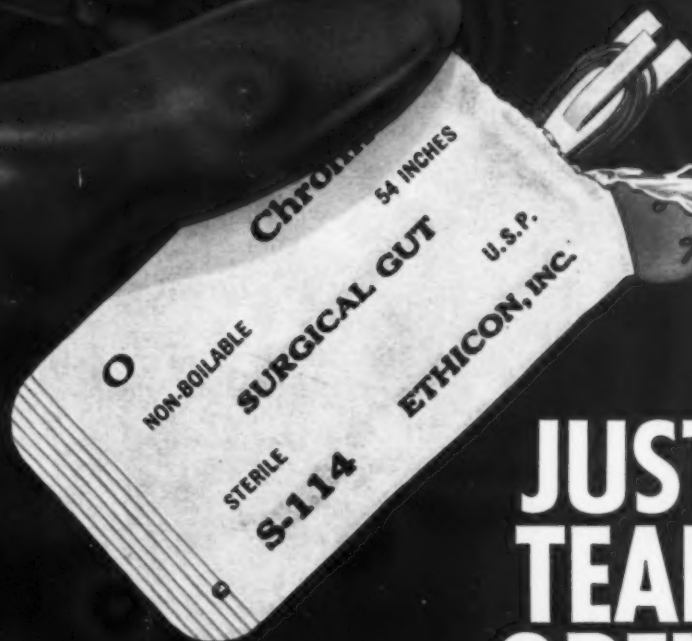
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W. Douglas Piercey, M.D., Editor



Obiter Dicta

Serving Sick Children

SELDOM has the devotion, enthusiasm, determination and sincerity of a small group of women been better exemplified than in the development of Ste-Justine Hospital in Montreal. Started in 1907, the first hospital was a house on Saint Denis Street at Pine Avenue. Within fifty years the hospital has expanded progressively on several sites and now contains some 860 beds in a modern building on Côte Sainte Catherine Road near the University of Montreal.

The history of Ste-Justine demonstrates what can be accomplished by voluntary effort when a dedicated group of women undertake to meet an imperative need, and when their zeal fires the imagination of the public. The new Ste-Justine Hospital is a monument to fifty years of hope and effort. It is a unique story of success, beyond the wildest dreams of its founders. Unique also is the fact that during this whole period the board has had but one president—Madame L. de G. Beaubien. Her vision and courage, in guiding the affairs of the hospital since its inception, has led to its becoming one of the largest for children to be found anywhere. Ste-Justine Hospital, with its ultra-modern services, is a tribute to her determination in the face of many frustrations.

Much of this issue is devoted to the story of Ste-Justine. In the twelve articles that follow we attempt to tell something of its history, its present lay-out, and its day-by-day work on behalf of sick children.

Au Service des Enfants Malades

LE développement de l'Hôpital Ste-Justine de Montréal est un exemple peu commun de ce que peuvent faire la dévotion, l'enthousiasme, la détermination et la sincérité d'un petit groupe de femmes. Fondée en 1907, l'institution originale était une maison de la rue St-Denis au niveau de l'Avenue Pine. En l'espace de cinquante ans l'hôpital s'est progressivement étendu sur plusieurs emplacements et sa capacité actuelle est d'environ 860 lits dans un bâtiment moderne de la Côte Ste-Catherine près de l'Université de Montréal.

L'histoire de Ste-Justine montre ce que peut accomplir l'effort bénévole quand un groupe de femmes déterminées entreprennent de répondre à une nécessité impérieuse, et quand leur zèle enflamme l'imagination du public. Le nouvel hôpital Ste-Justine est la consécration de cinquante années d'espoir et d'effort. C'est l'histoire d'une réussite incomparable, qui surpasse tout ce dont ses fondatrices avaient pu rêver. Unique également est le fait que, tout au long de cette période, le conseil d'administration ait été présidé par la même personne, Mme L. de G. Beaubien. La perspicacité et le courage qu'elle a apporté à la conduite des affaires de l'hôpital depuis sa création en ont fait l'une des plus grandes institutions pour enfants qui soient au monde. L'Hôpital Ste-Justine, avec ses services ultra-modernes, est un tribut à la détermination dont elle a fait preuve face à bien des espoirs déçus.

Une bonne part de ce numéro est consacrée à l'histoire de Ste-Justine. Dans les douze articles qui suivent nous essayons de vous parler de son histoire, de l'institution telle qu'elle existe actuellement, de ce qu'on y fait pour les enfants malades.

Liking Our Work

THE ancient command, "cast thy bread upon the waters: for thou shalt find it after many days," had particular significance for agriculturists living on the banks of the River Nile. In a broader sense, it has an inner meaning for all of us today, regardless of our vocation. In our daily work, it is in the giving of ourselves and the striving for perfection that we develop our skills, increase our knowledge and grow in moral stature.

It has been said that it is not so much what we do, but how well we do it that counts. Perhaps the best compliment that can be paid any employee is that he or she is a craftsman. This term should not refer solely to any particular calling, but should imply that the person is able to do good work, whatever that particular work may be. Many people work not because they want satisfaction, but because they must eat. Many believe that the less one works the more happy one will be. But if the time arrives when machines do all our work, it will not take us long to become completely bored to death.

Some people take personal pride in their work—satisfied from doing a job well. We should not regard any task or occupation as being so menial that it does not possess a certain dignity. A person who sweeps a floor well, or cleans a wall in a business-like fashion is contributing to society. All work can be made interesting, but what we make of any task depends on what we ourselves put into it. A worker can get personal satisfaction from any job. Whether we do get satisfaction from our work or not depends very much on our over-all attitude and the enthusiasm with which we approach our duties. Any undertaking leaves room for creative thought. There may be several ways of doing the same job; some better than others. If we are satisfied in continuing old methods, without ever looking for better ways, then certainly the work will become routine and uninteresting. On the other hand, if we approach our work with some feeling of its value, and regard it as a chance to express ourselves, then we can really enjoy it. What is needed most is imagination and originality.

A block of wood may mean many things to many people. Some may regard it merely as a piece of waste timber, others may see several uses to which it can be put. To the wood carver it is the raw material in which already lies some intricate design which he carries in his imagination; but it takes this imagination and his skilled hands to make it a reality. A piece of canvas and some paint, in themselves, may not give any great sense of well being to anyone who sees them; in the hands of a skilled artist, however, they become the media through which an enduring piece of art is created. Yet, we today are used to mass production methods and conformity seems to be the watchword of the times. In our civilization, we must guard against becoming stereotyped.

However, there is also a danger that we may become so centred in our work, and so specialized in our education, that we will not permit ourselves to develop completely. Too frequently, because of the

pace at which we pursue our endeavours, we believe we must keep pushing aside interests which lie apart from our work. In doing so, we lose the opportunity to fill and stimulate our minds with what improves our lives.

The willingness to develop a wide knowledge, well beyond the narrow necessities of our own particular work, can well make the difference between a mediocre worker and an excellent one. Most people have more capacity, more creative power than they usually call upon. If we are willing to put a part of ourselves into every task we perform, we can be assured that we are making a significant contribution to society.

Training an Understudy

IF THE average hospital administrator were asked, "What is the most important function you perform for your hospital?", he would have difficulty in supplying a ready answer. If we compared the replies of many administrators we could expect a good variety of answers. It is not our intention to give an absolute answer to the question, but rather to point out one area of administrative responsibility which is frequently overlooked. We refer to the necessity of providing for and training an understudy. No aspect of administration requires a greater measure of wisdom than the selection and proper employment of executive staff. The need for long range planning in executive selection and development is a basic management function.

The concept of management that has come to the fore on this continent during this century has been one of team work. While there is one top executive position, there are many divisions and departments giving their support. It is a duty of management to see that there are understudies in each department and division; to see that they receive adequate training so that, when necessary, they can take over more responsibilities in the organization. It is a primary duty of the chief executive to see that there is a competent understudy to himself—a person who receives the proper background, orientation and training. In general, this principle is much better understood in industry than it is in hospitals.

For chief executive officers this is a responsibility which cannot be delegated; yet in many instances it is not recognized as a responsibility at all. In some cases no thought has been given to the matter; and in other cases the administrator hesitates to train a competent understudy—perhaps because of the fear of losing his own position some time in the future. The board of trustees itself may even discourage the principle on a budget basis, to find later that, for some unforeseen reason, they are in somewhat of a dilemma.

Many hospital administrators today are developing a new attitude which is akin to that long held by the medical profession. Just as the physician expects the next generation of doctors to have more knowledge and skills, so today's administrators expect that as a result of study, practice, and research, their successors will be more advanced in the art of management. All of us like to believe we are good administrators, bearing in mind all that is implied in the term. In the final analysis, however, we are not discharging our complete managerial function unless we are actively engaged in training our understudy.

Historique de Ste-Justine

un hôpital

pour les enfants

Mme L. de G. Beaubien



EN 1907, alors que de partout se faisaient sentir les ravages de la terrible mortalité infantile, un mouvement de pitié, de charité, de patriotisme surgit à Montréal, dans le but de réagir contre ce fléau qui devenait un danger pour la famille, cellule-mère d'une société et garantie de la survivance d'une nation.

Ce mouvement fut reçu avec enthousiasme et secondé par les familles qui souffraient déjà tant de ne pouvoir obtenir de place pour leurs enfants malades dans les hôpitaux d'alors. Il fut également endossé par les membres de la Faculté de Médecine qui se rendaient bien compte que cette initiative, pour porter ses fruits, devait être organisée et reconnue sur une base d'enseignement pratique en pédiatrie.

Celles à qui semblait confiée cette importante mission ne possédaient pas les qualifications standard exigées par les diplômes officiels; de leur coeur, de leur volonté, a surgi la conviction nécessaire à l'accomplissement d'une oeuvre découlant du grand principe de charité et de devoir social.

En mai 1907 donc, une femme médecin, Dr. Irma Levasseur, s'adressait à une autre femme, bien

connue par son coeur très ouvert à la charité, Mme Alfred Thibaut, la priant d'organiser un hôpital d'enfants. Comme résultat, une soirée de vues animées fut donnée et rapporta la somme initiale de la fondation, soit \$87. L'Honorable Damien Rolland, conseiller législatif, prêta une maison qui devint le berceau de l'Hôpital lorsqu'y fut admis le premier bébé, en novembre de la même année.

Après que l'idée se fut matérialisée il fallut effectivement créer

une organisation et c'est à ce stage qu'on fit appel à Mme L. de G. Beaubien d'agir comme première présidente et de s'adjoindre les personnes qui pourraient l'aider à fonder un hôpital pour enfants.

Le 26 novembre 1907, un premier Comité de sept dames était formé.

A l'encontre de toute entreprise d'envergure reconnue d'intérêt général, cette oeuvre semblait avoir un programme très simple tout trouvé: celui de créer un hôpital pour les enfants, mais l'objectif financier n'avait encore aucune définition d'action pratique. La sincérité et la naïveté de ces jeunes fondatrices n'affectaient en rien leur enthousiasme. Comment le tout s'est-il accompli? Dieu le sait, et notre génération l'a vu; tant de nos enfants ont été soignés et guéris et un si grand nombre de notre jeunesse universitaire a bénéficié d'un enseignement pratique dans un vaste champ d'observation!

L'existence légale de la corporation de l'Hôpital Sainte-Justine fut proclamée par une loi sanctionnée en mars 1908.

La modestie des débuts fut telle que l'Hôpital obtint alors le droit de posséder des immeubles au montant de \$200,000. Si l'on compare ce droit de possession avec celui de 1957 qui est de \$30,000,000, on comprend dans



Mme la présidente

L'auteur est présidente du conseil d'administration de l'hôpital Sainte-Justine.

quelles proportions s'est développé le petit noyau de 1907.

Quelques incidents particuliers ont marqué nos démarches à la Législature de Québec: notre administration étant féminine et la femme dans la province de Québec devant obtenir l'endossement de son mari pour la signature de tout acte légal, il fallait obtenir par une loi la libération de cette sujétion et permettre aux membres de la Corporation de l'Hôpital d'endosser les obligations d'une administration responsable.

L'Honorable Sir Alexandre Lacoste, alors Juge en chef de la Cour d'Appel de la province de Québec, dirigea de ses conseils bénévoles cet embryon d'organisation charitable et son fils, Me Paul Lacoste, C.R., pilota les administratrices dans les dédales légaux d'une organisation nouvelle.

En janvier 1908 formation du premier Bureau Médical sous la présidence du Dr Joseph E. Dubé et même malgré toutes les prétentions dont on pouvait nous accuser une première école de gardes-malades fut mise sur le métier.

Enfin, l'organisation administrative, médicale et légale avait pris corps et on décida de louer une maison rue Delorimier et en mai le nombre de lits de malades fut porté à 32. Par nos puissants amis les journaux, un appel fut lancé pour solliciter des meubles de quelqu'âge qu'ils soient et quelle que soit leur valeur. Les réponses furent si nombreuses que l'Administration aussi bien que le personnel durent se faire peintres, menuisiers, ou exercer quelque autre métier pour profiter de ces aubaines. Des lettres nous arrivèrent toutefois protestant qu'un hôpital sérieux ne pouvait

commencer ainsi—on était en 1908. Que dirait-on d'autre aujourd'hui? Mais la foi dans la nécessité d'aider nos enfants nous rendait sourdes à toutes ces représentations tendant à nous décourager.

Des dispensaires furent ouverts, une Goutte de Lait organisée. L'oeuvre naissante était aussi soutenue par un comité de couture formé de travailleuses généreuses, habiles et fidèles qui venaient toutes les semaines garnir nos armoires d'une lingerie à peu près suffisante. Soucis financiers, organisations hospitalières incomplètes, surintendantes inexpérimentées, tous les fardeaux semblaient nous tomber sur les épaules en même temps. Heureusement, dès le début, il nous fut donné de recevoir l'aide de deux infirmières compétentes pour diriger les soins qu'exigeaient nos petits malades. Des médecins confiants dans l'oeuvre se dévouèrent au service de cet hôpital naissant. Les obstacles stimulaient l'enthousiasme.

En mars 1910, enfin, les religieuses espérées et attendues arrivèrent au nombre de six. Ces religieuses de la Congrégation des Filles de la Sagesse venaient directement de France. L'Hôpital était dans la meilleure voie et les tâches se partageaient. Les enfants malades pouvaient entrevoir une possibilité d'hôpital adéquatement organisé.

Si j'insiste sur toutes ces différentes phases de notre entrée dans la vie hospitalière, c'est que je voudrais bien prouver que rien ne peut égaler la persévérance dans une entreprise dont le but répondait à l'urgence de protéger et sauver nos enfants.

En 1910, dans le 3ème rapport annuel de l'Hôpital, on lit que le

Dr Raoul Masson, professeur titulaire en pédiatrie à l'Université, "rêvait d'un hôpital très grand..." Quelle satisfaction ce grand ami des enfants aurait à voir aujourd'hui un hôpital aux dimensions de son désir et répondant aux besoins de nos protégés.

Le don de terrains par l'Honorable Louis Beaubien et deux de ses fils, Joseph et Louis de Gaspé, aida à concrétiser un nouvel immeuble rue St-Denis.

En 1912 fut entreprise l'étude d'une construction définitive suivie de son exécution. Dès 1914, pour la première fois l'assemblée annuelle avait lieu dans le nouvel immeuble non terminé il est vrai, de sorte que cette réunion fut tenue dans la pièce destinée à la buanderie, non encore pourvue de son équipement. Mais peu importe, notre oeuvre se concrétisait et quelle joie d'entrer dans le chez-nous de nos petits malades!

En même temps que le côté physique et matériel se dessinait, la valeur médicale et scientifique s'affermissait. Le 8 novembre 1914, avait lieu la bénédiction de la nouvelle maison et l'affiliation de l'Hôpital Sainte-Justine à l'Université Laval était signée.

Ce nouvel hôpital avait une capacité de 87 lits et une installation en rapport avec les exigences que ses moyens lui permettaient de rencontrer.

La bénédiction de la nouvelle maison avait lieu le 8 novembre 1914, veille de la fête patronale de l'Hôpital. En effet, tous les ans à cette date, était honorée Sainte-Justine, petite martyre romaine. Il était donc tout indiqué que cette enfant de sept ans fut choisie pour donner son nom à un hôpital pour enfants.

En 1916, les hôpitaux Hôtel-Dieu, Notre-Dame, Victoria, General et Sainte-Justine s'unirent pour obtenir de la Ville de Montréal du secours financier afin d'aider à rencontrer une partie du coût d'opération des hôpitaux; c'est de ce mouvement qu'est né "le Sou du pauvre" qui, pendant sept ans, prépara la voie à la loi de l'Assistance publique. Déjà apparaissait le plus grand besoin d'aide requis par les hôpitaux pour enfants.

En 1918, au moment de la proclamation de cette loi et du classement des hôpitaux comme valeur de catégorie, pour que Sainte-Justine fut reconnu comme hôpital général, l'intervention de la Lé-

(Suite à la page 96)



The hospital continued to grow—1926—L'hôpital continue à se développer—1926



A brief tour of the new Sainte Justine pour les enfants

Sr. Noemi de Montfort, f.d.l.s.

THE hospital is now in its new location at 3175 St. Catherine Road, Montreal 26. October will see the first anniversary of moving day and mark the beginning of another half century of deep concern for the health and welfare of our children.

The history and activities of the hospital, aspects of construction, the operation and functions of several departments are dealt with elsewhere in this issue of the journal. Here is but a condensed review of the entire building. Numbers referred to during the proposed tour will indicate the wings, as shown on the diagram (next page).

The numbering of wings, odd and even, respectively west and east, facilitates orientation throughout the buildings. Much confusion is avoided in the training of new personnel, guiding of visitors, assignment of rooms, preparation of maintenance schedules, and in the distribution of keys and supplies. Four numbers are used to identify any one room—e.g., 7620 refers to floor 7, wing 6 (east side), room 20.

Because there is a double slope

Sr. Noemi de Montfort is assistant administrator of the hospital.

in the land, four floors are found below the main entrance level and are known as A, B, C, and D. The location of entrances and elevators have been planned to avoid cross traffic. The main entrance, large and bright with an attractive children's corner, receives elective patients, as well as hundreds of visitors daily. A pair of elevators at both junctions, 1 3 5 and 2 4 6, are assigned to visitor traffic from the first floor to the centre of the three nursing units in each junction on the five upper floors. Incidentally, every day is visiting day from 2 p.m. to 3 p.m. and from 6:30 p.m. to 7:30 p.m.

Medico-social service and patients accounts are in 2 near the main entrance. Elective patients are attended at the admitting offices in 1, next to a pair of elevators assigned for the transportation of patients. Ambulance patients enter at 3, and the occasional helicopter patient lands on a reinforced roof on wing 9.

Patient services: The hospital has been planned to accommodate 860 patients, approximately 40 per cent under two years of age, 22 per cent pre-school age, and 38 per cent six years and over. The one-, two- and four-bed rooms pro-

vide flexibility for segregation of age, sex, and disease. In 1 and 2, on every floor, mother and child can be accommodated in the semi-private rooms.

Nursing floor: The triple nursing units, two per floor, are self contained and identical on the five nursing floors: 3rd, private rooms; 4th, maternity and prematures; 5th, surgery; 6th, medicine; 7th, specialties. At the junction of corridors is an information desk for the three units, along with a large waiting room, supervisor's office, three head nurses' counters, three students' charting desks and a medical suite, parents' consultation and interns' laboratory, medication room, combined clean utility and kitchenette, a conveyor room for receiving and dispatching supplies, a treatment and examination room, and a bed-pan room.

On the service corridor are linen room, housekeeper's room with foot-controlled waste and linen chutes, sterilizer for decontamination purposes, high humidity room, isolation rooms, and a dietitian's office and floor pantry for teaching and demonstration to parents. There is one classroom per floor, between 1 and 2.

It was felt that nothing should

be spared to prevent cross-infection—a constant menace in a children's hospital. The four-bed baby units provide isolation of each baby under two years of age, individual scrubbing and bathing facilities, disposal of soiled linen, oxygen and suction, and close viewing by parents and nursing staff through an observation corridor. Low window sills create a pleasant atmosphere for both child and staff. Facilities to cope with communicable disease in the nursing units, available on all patient floors, eliminate the transfer of patients and protect the staff who administer treatment, as well as the maintenance personnel.

Light is plentiful on all floors, and the view from the waiting rooms toward Mount Royal, the University of Montreal and Saint Joseph's Shrine enhances the attractiveness of the solarium which are located on every floor between each wing. They are accessible to patients, visitors, and staff in their respective quarters.

Administrative services are located on the lower floors of 2, 4, and 6. On the second floor, the administrative suite is located in 4, nursing and public relations in 2, and volunteers and fund raising in 6.

On the first floor, the medical records department in 6 ties in

with doctors' quarters in 4. The unit medical record system and terminal digit filing are used, and as many as 400 records travel back and forth daily via pneumatic tube or conveyor basket to nursing units, out-patient department or ancillary services. Doctors' in-and-out register, dictaphone and writing facilities close to the mail lockers, lounge, cloak and wash rooms line up on the north side in 4. The medical director's suite and medical library are on the south side overlooking the main entrance.

On floor A, general accounting, statistics, and centralized purchasing are in 6. The switchboard adjoins telephone staff quarters in 4. Merchandise entrance and inventory control are on C in 1, with general stores and subsections for kitchen and linen extending in 2. Distribution of all supplies is by conveyor or messenger. The printing shop is in 6 on B floor next to the mail room.

The out-patient department is located in the lower west section 1 3 5. The entrance is at main entrance level. Registration and admitting goes on in 1. Here too, pharmacy dispensing is carried out.

In 5 a complete x-ray unit and two fracture rooms service both the surgery-orthopaedic clinics and emergency in 3.

On the second floor in 1 are pre-

and post-natal clinics and the electro-encephalography department. Ear, eye, nose and throat departments are in 3, and scheduled medical clinics in 5. On floor A in 3 and 5, physical medicine and rehabilitation, with its own entrance off the second terrace, has provision for an outside covered gymnasium and play court. The brace-shop next to "physio" eliminates travel distance for readjustment of apparatus. The dental clinic is also located on A in 1. On B floor, the audiology department has complete testing equipment in sound-proof rooms. Speech rehabilitation is located in 5 next to the psychiatry clinic.

A large conference and teaching room at the extremity of 5 is to be found on the four clinic floors: medicine, surgery-orthopaedics, physical medicine and psychiatry. Three teaching amphitheatres are located in 9 on A floor, and three large conference rooms, in 1 and 2 on the 9th floor.

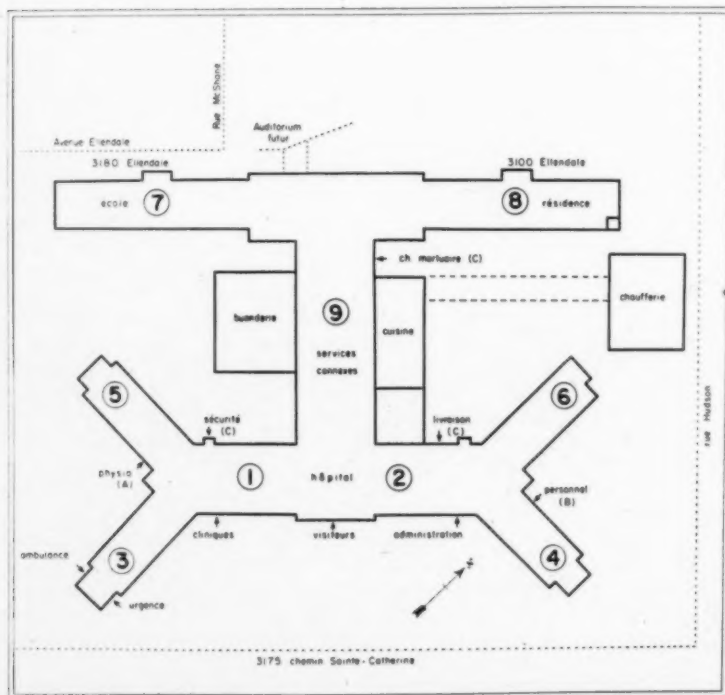
Ancillary Services

Radiology, at the main entrance level in 9, is accessible to both out-patients and in-patients from 1 and 2. On the west side the six diagnostic rooms are arranged in pairs. Each room is provided with a film change room, two dressing alcoves with locks, a toilet and rest room. This arrangement is appreciated by the patients, who are assigned to a dressing room as soon as they have checked with the receptionist. To the right, a photography studio and medical arts department is followed by the therapy department, and the administrative offices, conference and film filing rooms.

Between the double corridor, the developing machine is located next to the filing and lecture rooms. At the far end of the wing the cardio-pulmonary catheterization room is opposite the angio-graphic room. The radiology department services and controls the decentralized units: one cystoscopic and one radiographic in surgery, one radiographic in the dental clinic, and one complete diagnostic unit in emergency.

Clinical laboratories are on the second floor in 9, next to the clinics and available to the 30 nursing units on the five floors above in 1 3 5 and 2 4 6.

Upon entering the department the office is at the left and seven specimen test rooms are at the right. One is air conditioned to



maintain constant temperature. A double corridor separates the biochemistry and bacteriology from haematology, blood-bank, serology, and the one-year old virology department. Space for research has been provided at the extremity of 9 next to the library, conference and demonstration rooms.

Pathology is located on the 5th floor, north side, and is equipped with its own photography unit, conference, museum and teaching facilities. The combined cold room and funeral chapel is on C floor in 9 with direct elevator connection.

Gas incinerators in both autopsy rooms, bacteriology and pathology, permit immediate disposal of contaminated material and experimentally infected small animals. Centralized running distilled water supplies all the laboratories. With the use of an automatic washer, one attendant can handle all the glassware.

Small laboratories for routine or teaching purposes are set up in the nursing units, clinics, and emergency department.

Specimens are brought by means of conveyor baskets to a central distribution and control station located midway between the clinical laboratories.

Surgery

The surgical suite is in 9 on the third floor. There is a large waiting and bed parking area at the entrance in 1. Rooms are 18' x 20', in green tile, arranged in pairs with scrubbing facilities, instrument washer and high speed sterilizer, solution cabinet, clinical sink and mop closet. Stainless steel cabinet work, flush with the wall, includes a soiled linen pass-through unit for collection on the corridor side. Twenty rooms include two bronchoscopy, one cystoscopy, and two plaster rooms. There are two "T. and A's" connected to the suite in 1. A 16-bed recovery unit at the entrance, north side, contains one isolation room accessible to relatives.

On the 9th floor, an experimental surgery department, separated from 1 and 2 by ventilating equipment, provides a quiet and complete unit for research. On the north side, five stalls for post-operative canines, a pre-operative room supplied with adequate water and feeding installations, and a utility unit comprising bath, preparation table, and autopsy table. On the west side, there are laboratory and operating rooms where aseptic techniques may be maintained;



Above—children have their own corner in the main lobby; middle—one of the nursing stations which stand at the junctions on each floor; below—a tiny patient sleeps in the four-bed baby unit.



Operating room showing wall-hung x-ray control panel, and soiled linen pass-through door.

and finally a conference and work room, in the north-west corner, with plenty of sunshine, shelving and cupboard space for books and equipment, provides a place where Fellows will have all the facilities and the privilege of working to their hearts' content on projects likely to help mankind.

Obstetrics

A 70-bed maternity ward is located on the 4th floor in wings 1 2 3 5. Expectant mothers are admitted directly to the preparation unit next to the labour and delivery rooms in 9. A bright, airy waiting room is appreciated by the fathers.

A pair of nurseries is located in each wing and accommodates from eight to ten new-borns. To parents and visitors, new-borns prove to be the "best show in town" when seen through the "no curtain" windows in the observation corridors.

A central service cleans, prepares, and sterilizes supplies for all departments, including surgery and obstetrics. An illustrated manual of sterile trays was prepared to cope with moving day and it still proves its worth.

The return of used supplies is managed by baskets conveyed on vertical belts, in 1 3 5 and 2 4 6 respectively, which meet horizontally at the junction of 1 and 2 on B floor and then proceed in 9 to a spiral discharge in the stripping section of central service.

The north side houses separate cleaning areas for formula bottles, gloves, and solution bottles. On the south side, are surgical supplies and packs. The issue of clean sup-

plies occurs at the transfer point in 1 with control for dispatching, either east or west, to a designated floor.

The pharmacy in 1 uses the conveyor extensively, at the transfer point, for regular and rush orders; a dumb-waiter connects main pharmacy and pharmacy dispensing on floor 1 in the out-patients department.

The food service is centralized for patients on C floor in 9. The main kitchen is of sunlight yellow tile, next to the merchandise entrance and bulk food stores. The formula room is in 2 on B floor. Cafeteria, dining-room, and snack bar, are in 9 on A floor, which is the only connection between the hospital and the residences.

The laundry in 9, C floor, south side, is 18 feet high and is of blue glazed brick. Soiled linen in bags, from the hospital and the residences is conveyed from floor D to the mezzanine B floor. The linen chute in 9 taking care of operating room and obstetrical linen, empties into the sorting area. It is then fed through hoppers directly into the washers below on C floor. Clean linen is delivered by laundry staff and is stored on trucks in the nursing units.

Housekeeping headquarters are in 9 on C floor next to the laundry. The male float staff has its supplies and equipment in 2 in individual wire compartments and is responsible for the cleaning of floors, walls and windows.

Oxygen tanks which supply the piped-in system are located under

the west concrete driveway next to the maintenance shops in 5 on C floor.

A "security" chief officer exercises supervision on ventilation controls, fire alarm, exit doors, watchman's rounds, and elevators, via two-way talking system, master clock, and pneumatic tube pilot light. As many as 1,200 pneumatic tubes travel through the system daily. An officer is in attendance 24 hours a day and all calls for emergency service are channelled through this office.

Radiant heating in the ceilings is used throughout except in 7 and 8. D floor, on solid rock, is used in its entirety for the mechanical equipment of all the buildings, such as heat, light, power, and other services. The floor in wings 7, 8 and 9 is level with the residences, while the floor in wings 1 to 6 in the foreground is reached by a four-foot ramp. The heating plant is an independent building with a connecting tunnel on D floor.

Building and maintenance headquarters are strategically located at the junction of 1 and 9 on C floor.

Personnel

This department is split up as follows: on B floor at the junction of 2 4 6 off the doctors' parking court; and at a clerk's office at the entrance, open 24 hours, are the time clocks and timekeeper's office, centralized locker rooms, washrooms and lounges for some 500 employees. A separate stair serves to take personnel up from B to A floor to another set of facilities for another 700 employees. In 4, are offices for the personnel director, assistant directors, waiting room for prospective employees, and interviewers. Across the corridor, the health service, comprising waiting room, three examining rooms and two treatment rooms, is conveniently located to facilitate pre-employment examinations. A uniform service in 2 on A floor and payroll issue at the junction 2 4 6 next to general accounting, groups together all the services involved with the personal interest and welfare of the staff.

In residence 8, for salaried staff, one typical floor contains two groups of 14 rooms separated by the elevator lobby in the centre, plus a lounge, utility, and wash rooms. Single rooms with wash basin are appreciated, as

well as the spacious open veranda at the end of each floor. The housing accommodation in 7 for 243 student nurses is identical. Interns' quarters — 41 single rooms, living room, and open veranda are located in 9 on floors 4 and 6. Sisters' quarters are located in the recessed space between the pent-houses in 1 and 2 on the 8th floor.

An outside private terrace adjoins the living quarters of the different groups living in. Swim-



Transfer point of conveyor system near pharmacy.



Security office.

bridges. The third access from the hospital side makes for ease of circulation, the seating arrangement being amphitheatre.

A feeling of space, quiet, and harmonious inter-departmental relationship helps to retain the home-like atmosphere that has been one of the noteworthy features of the institution through the years. The new hospital stands as a tribute to the woman co-founder, Madame L. de G. Beaubien, and her associates who with faith in Divine Providence and the generous help of the community attempt to provide good patient care and the necessary services and facilities for the staff who, like themselves, dedicate their lives to the care of the sick and injured.

ming pool and gymnasium are in 9 on D floor, and an outside tennis court and skating rink will, in time, complete the recreational activities planned for the staff.

The patients have a terrace on the roof in 3 and 5 next to their play room and library on the 8th floor.

Open early and late to all who wish to meditate and pray, the chapel is located at the far end of 9 and is connected to the residences by two glass-walled



Sterile tray manual.



Main lobby

pour les enfants

The Architectural Point of View

Joseph Sawyer, A.A.P.Q. and
Henri S. Labelle, F.R.A.I.C.

L'HOPITAL SAINTE-JUSTINE pour les Enfants now occupies an ideal site of some 472,000 square feet on the northern slope of the Mount Royal. The structure proper covers an area of 133,500 square feet. The altitude of the building and the distance from its neighbours give it a magnificent view, quietness and an ample supply of fresh air. The advantages that accrue to the hospital in view of its proximity to the University of Montreal cannot be overstressed, as Ste-Justine is a teaching hospital.

The new Ste-Justine was in the planning stage for many years, and all the features which have been incorporated into the building were thoroughly studied by the architects who consulted a score of experts and the various categories of the hospital's personnel: administrative, medical, religious, and nursing.

Preliminary plans were drawn up by Jos. Sawyer and his staff between 1946 and 1950. Early in 1951, Mr. Sawyer chose as associate architect Henri S. Labelle; then both of them were hard at work for six years before they saw the completion of the project in 1957. Theirs was not an easy task—l'Hôpital Ste-Justine has a floor area of over a million square feet and a volume of 14½ million cubic feet. Furthermore, many special features were incorporated into the plans; for example, radiant heating, especially devised infants' cubicles, a complex conveyor system, an automatic switching pneumatic tube system, a centralized

food system, a helicopter-landing on the roof and a bomb-shelter four storeys below ground.

The construction is of reinforced concrete and the hospital is built on solid rock. The exterior is of brick veneer while various types of materials—plaster, glass, and tile—were used for ceilings, walls, partitions and floors.

The hospital is made up of three sections. All patients are grouped in the top five floors of the front section (buildings 1 to 6, see sketch). Every floor is divided into six nursing units of approximately 30 beds each—thus the total number of beds is 860, with 70 bassinets. Room accommodation varies from private rooms to four-bed wards.

The other six floors of this section, of which four are underground, are taken up by offices, outpatient department, storage, locker rooms and a bomb-shelter with 12-inch reinforced concrete walls and ceiling, and a capacity of 20,000 persons.

The northern section at the rear (buildings 7 and 8) is made up of two homes; one for the student nurses, with 235 rooms, and one for the hospital staff, with 256 rooms. The front and the back buildings are joined together by the central wing (building 9) which houses the operating and delivery rooms, and laboratories, the x-ray department, the cafeterias, the kitchen and the laundry. Also in this wing, there is a chapel seating 410 persons and a school for nurses equipped with classrooms, laboratories, library, gym-

nasium, auditorium and swimming pool. Still to be provided is an auditorium with a capacity of 1,100 seats.

The power house merits a special mention. It is a separate building connected to the hospital by a tunnel. Three oil-fired boilers, each with a capacity of 30,000 pounds of steam per hour, supply all heat, steam and hot water required by the hospital. In case of a breakdown, any two boilers, by working slightly above design capacity, can take care of the full load of the hospital for a short period of time, even on the coldest days. In addition, an electric boiler runs intermittently, whenever the Quebec Hydro has a surplus of power to dispose of. In the event of an electricity failure, a propane gas emergency generator takes over automatically in a matter of seconds so that essential services may not be interrupted. It supplies enough power to run nine elevators, light the operating rooms and corridors, stairs and radiology department.

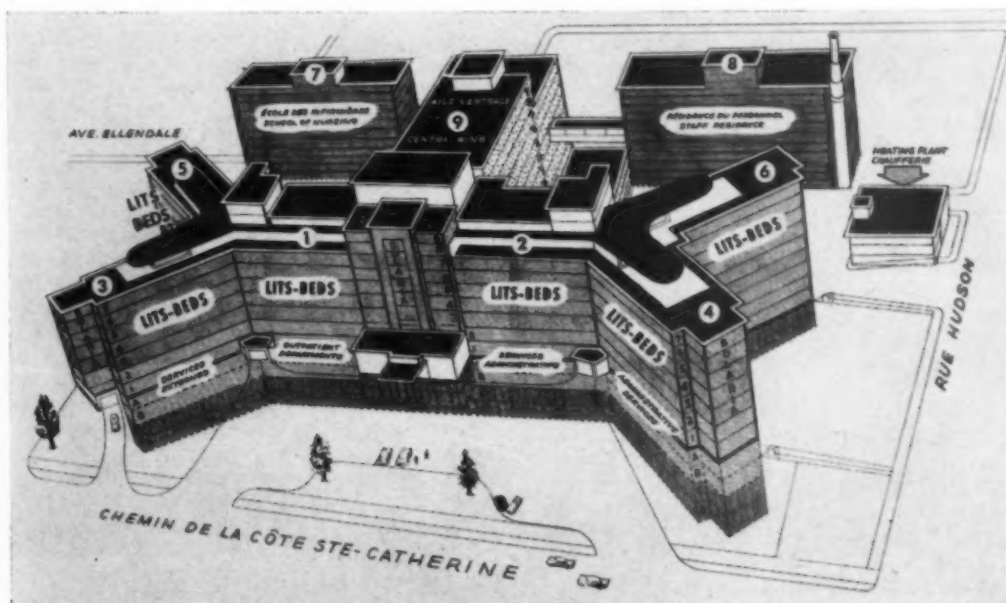
Except for the two residences, the whole hospital has radiant heating. More than 150 miles of copper tubing were installed in ceilings to provide the necessary heat.

A great deal of thought was

given to minute details in the planning of the hospital to minimize the maintenance problem. Unnecessary projections and dust collecting mouldings are non-existent, corners and edges are rounded, fixtures are flush with walls and ceilings, ceiling tiles in corridors can easily be lifted to reach ducts and piping, removable panels and doors give access to the rear of plumbing fixtures, counters and shelving (except in special cases) are of stainless steel. All window frames are of aluminum, and they swivel for washing from the inside. Corridor walls are covered with a resin impregnated fiberglass blanket which never needs painting and which is extremely resistant to shock and abrasion.

All these features are well worth their cost in a hospital for two reasons: (a) cleanliness is essential, and (b) as hospitals often operate on a deficit, all savings in maintenance are well appreciated.

It is not every day that a \$30 million hospital is built, and no architects have received more co-operation from all other groups concerned in its construction. L'Hôpital Sainte-Justine will undoubtedly long remain a monument to the devotion of the Canadian people toward their children.



The architect's block plan of Ste-Justine

Preparing to Move

Gaspard Massue

IT TAKES a great deal of planning to move from cramped quarters into a spacious building, five times the size of the old one. Physical preparedness is, of course, only a part of the whole problem. What about administration and personnel, rate settings and budgetary estimates? All these things have to be studied while thousands of construction decisions besiege you.

The board of administration of Ste-Justine's took all these problems in its stride and did, we feel, successfully solve most of them. Did it use any rare formula to arrive at its end or did it face the problems as they came along? Neither of these solutions were resorted to. Will, foresight and preparedness were the watchwords of the members of the board for a number of years. Problems were foreseen, studied, and possible solutions found long before they were encountered.

Ste-Justine Hospital has an administrative organization that is unique in North America and probably in the world. It is a lay and non-profit hospital and the members of its board are all benevolent women. The chairman of the board, and this is also unique, is to all intents and purposes the administrator of the hospital. Other members of the board, especially the treasurer and assistant-treasurers, as well as the secretary, also undertake, on a benevolent basis, certain tasks which are usually in the realm of the administrator or of the comptroller.

The administration of the hospital made up its mind in the middle 1940's that the construction of new quarters was imperative. An enlarged institution would, of course, require a somewhat different administrative set-up as well as additional administrative personnel.

M. Massue is director of administrative services at Ste-Justine.

In order not to undertake these changes in a haphazard way, the services of a firm of management consultants were retained in 1948 to make a survey of the existing administrative set-up and to make recommendations, keeping in mind the future expansion of facilities. This survey proved very helpful and although not all the recommendations were fully in effect, they served as a basis of a long-range development program.

As the plans for the building of a new and enlarged hospital were passing from the dreaming stage to the drawing board, additional key personnel were appointed to take their share of the heavy administrative load. The personnel department was reorganized in 1948; the post of director of administrative services was created in 1949; and in 1953, a professional accountant was named head of the accounting department; and in 1957, an assistant to the Mother Superior was designated. Many other changes were contemplated and adopted as the construction progressed or as soon as the move into the new building came about. The fields affected were out-patient and emergency departments, nursing, school of nursing and business offices. These changes were necessitated by the new lay-outs and the need to subdivide much enlarged departments.

Under the board of administration and, in particular, its chairman, the executive administrative set-up is divided among the following branches: (a) the medical branch which is headed by a medical director; (b) the "régie interne", i.e., the internal organization which is directed by the Daughters of Wisdom, a religious order which has 65 members on duty at Ste-Justine's; and (c) the administrative services which are under a director of administrative services.

A definite list of services and

departments fall under each of these three main divisions and the echelons afterwards are similar to those of any large general teaching hospital.

Because of the nature of our administrative organization, we have to work a great deal within the framework of committees. This method may seem cumbersome, carrying with it certain disadvantages; however, over a period of time, it has proved its worth. Its main advantage lies in the fact that members of the board of administration sit on these committees and are, therefore, very familiar with all the problems of the hospital. When problems are submitted at the board of administration meetings and decisions made, the members know in advance all the facts.

The most important committee of the hospital is the liaison committee which comprises the chairman of the board, the treasurer, the medical director, the mother superior and the director of administrative services. It is at these meetings that all administrative problems are studied and their solution delegated to one of the three administrative branches represented. If the solution of the problem submitted is beyond the power of these executives the matter is referred for decision to the board of administration. Incidentally, the board of administration meets regularly once a week, all year around.

Other committees have been holding regular meetings for a number of years, and besides looking after current problems, they were, throughout the construction years, very much aware of what lay ahead. At each meeting some aspect of future policy was brought up for consideration. These committees were: personnel, salaries and wages, rates, credit, and office procedures and systems.

Furthermore there was an out-patient department committee as well as a medical records committee on which were sitting, besides members of the board, the director of administrative services and representatives of the régie interne and members of the medical staff.

During the course of construction, various members of the construction committee met from time to time with heads of the administrative departments — personnel, both general and nursing, account-

(Concluded on page 114)

NURSING in a modern hospital has been highly influenced by the rapid changes in the health field in the past two decades. When one studies the activities of nursing in a university hospital of 800 beds, the principal objective still remains the care of the sick and injured, prevention of disease and promotion of health. But when more and more emphasis is placed on education of physicians, nurses and other personnel, and on the advancement of research in scientific medicine, it becomes evident that the concept of the nursing service, its functions, and its work program must, of necessity, evolve constantly.

Modern patient care encompasses prevention and rehabilitation as well as diagnosis and treatment. These new objectives were also considered in the organization of the nursing department in our new hospital. All facilities in the nursing units have been planned to meet the most complicated physical needs of the young patients as well as their mental, social, and spiritual needs. Therefore the interpretation of our nursing program contains new policies, rules, and regulations for better service to all patients.

The leadership of our nursing service comes from the administrative board of the hospital, in close co-operation with the medical board. The director of nursing is the liaison among the hospital authorities, the faculty of the school and the department

Sr. Laurette is director of nursing.

heads. She is responsible for defining the aim, standards and policies of the service, and for interpreting them to all of the nursing personnel so that lines of authority will be clearly defined. She is expected to establish principles of proper management and supervision, evaluate the activities within the service and delegate nursing authority according to present needs and conditions. It is clear that nursing functions today range from the very simple ones to the highly complex, and that the differentiation of these must be based on the level of judgment and the degree of skill required in meeting specific nursing situations. It is her duty to interpret to all nursing personnel the objectives of the institution, to study and evaluate the needs of the nursing department and present them to the administrator. She must measure the strengths and weaknesses of the service at all levels, studying reasons behind weaknesses, and being prepared to offer to each member of her staff the most comprehensive guidance.

St-Justine's hospital nursing service, with 500 professional and auxiliary nursing personnel, is at present taking part in several programs designed to improve co-ordination of effort between the nursing services of other hospitals, and within the various nursing departments of our own hospital. At the request of the administrator, the director of nursing attends and presents her report at the monthly meeting;



pour les enfants

Nursing Service and School

Sr. Laurette, f.d.l.s.



Many lessons go on at once in the nursing school.

the school of nursing is also represented at the weekly meetings of the administrative board.

The head nurses of all clinical departments meet twice a month and the director of nursing meets with her graduate staff in an informal conference twice a month to transmit new decisions or to discuss new clinical or professional problems.

The nursing service operates on a "decentralized" plan. A qualified nursing administrator assumes the major responsibility for the staffing and operation of her department. She has several supervisors, head nurses, and clinical instructors to assist her.

But to supplement the nursing staff and to give the professional nurse more time for administration, supervision, and personal contact with her patients, the team method of nursing is being tried in an informal manner. Many qualified and non-qualified auxiliary workers and nurses' aides have been introduced in the team and very shortly one full-time assistant will be responsible for the planning and execution of an "on-the-job" training program.

A new procedure manual of nursing techniques has been carefully prepared by our clinical instructors as an educational contribution to better patient care. The maternity program includes optional courses in preparation for labour (natural childbirth), and courses given to the mothers on infant care. The patient teaching program has become so important that it has necessitated a full-time instructor for patients. Student nurses studying in obstetrics and gynaecology learn how to conduct conferences with expectant mothers, show them how to practise tension-relaxing exercises and encourage them to ask questions after the baby is born. An in-service program has also been instituted to orient new staff to the nursing program of our hospital.

The School of Nursing

The director of nursing maintains close integration and correlation between the school of nursing, the hospital administrative and medical authorities, and other departments in the hospital.

The director of nursing education is responsible for the administration of the school and of the educational program. Twelve instructors, two of whom have the

status of assistant directors of nursing education, and a dietitian devote their full time to teaching. The first assistant director of nursing education assumes responsibility for the planning of the three-year basic course for students and is also responsible for the nursing arts and clinical teaching program.

Although nursing education and nursing service function as independent units, there is free communication between the two. The head nurses play an active rôle in the education of the students. They have had post-graduate preparation on a university level or post-graduate experience in recognized hospitals of the United States and other foreign countries.

The structure of the nurses' home allows a congenial atmosphere that will benefit all students, regular and affiliate; and facilitate teaching as well. The nursing arts' area reproduces the various types of units in the hospital with its new furnishings, facilities and equipment; and laboratories for chemistry, biology, and nutrition.

All types of classrooms have been planned and are now organized. The school library is large

and contains more than 3,000 books and professional, cultural, and other varieties of magazines.

To forget hospital fatigue and study hours, the most appreciated innovation is the single room accommodation. There are also twelve reception and date rooms for students' visitors, next to the entrance lobby. A small private oratory is on the fourth floor, where solace and guidance may be found in recollection and prayer. Nothing has been neglected by the board of administration to offer the students a homelike residence and adequate teaching facilities even though it involved large, but necessary, expenditure.

We do feel that under present conditions it will be relatively easy to carry on, with still more enthusiasm and success, towards our professional goal which may be summarized as follows: happiness and a good education for our students, superior training and valuable experience for post-graduates in paediatrics, obstetrics and prematures; job-satisfaction and an honourable situation for the entire staff, and above all the most complete realization of every one's objective—better total and skilful patient care.

Medico-Social Service

pour les enfants

Gaston Lapierre, M.D., F.R.C.P.

MEDICO-SOCIAL service is not new to Ste-Justine. The service has been under the supervision of a physician since 1932, but it did exist before for many years in a limited way—with only a graduate nurse directing the department.

Credit is certainly due to those pioneers of the first hour who took the initial steps in a difficult time—especially Euphrosine Rolland, the founder of our service. In 1932, however, Dr. Gaston Lapierre was appointed director of the department. Nurse Juliette Trudel was his assistant, and three graduate nurses and two students acted part time.

During the summer of 1934,

Dr. Lapierre is director of Ste-Justine's medico-social service.

regular visits to children who had received B.C.G. injections against tuberculosis since 1928 were organized. Those visits were considered indispensable to control the efficacy of this test's prophylaxis, and also to revaccinate the children, if necessary. Another nurse was appointed to the staff at this time, and she was assigned to the vaccination of the newborn babies in our hospital as well as to the visiting of the children at their homes.

The personnel of our service, becoming more and more convinced of the importance of the social character of our department, due to the experience acquired while in contact with the numerous problems they met regularly during the exercise of their duties, continued their visits

throughout Montreal. They explained the application of the prescribed treatments; and organized, when necessary, hygienic practices in the home, making dressings, pursuing inquiries, and helping indigent families whose financial situation did not permit them to continue adequate treatments. All the year long, during the cold months of winter and the hot spells of summer, our nurses co-operated in accomplishing their useful and humanitarian deeds.

In 1937, another nurse was assigned to the B.C.G. section of the department, as the patients to be controlled became too numerous, and in 1955, it was necessary to add yet a third nurse for the same purpose. Because of the increasing activities of the department, a second secretary was also added to the staff. In 1937, a follow up was developed—which meant visits to the patients previously admitted to the hospital and the control of their actual condition, helping them as far as it was possible.

In 1953, all sections of our social service were combined under one group under the name of "medico-social service", with Dr. Gaston Lapierre as general director. The service now follows up all cases, providing the necessary instructions, especially in the prevention of sickness, in the protection of the mother and the baby by instructions in pre- and post-natal care, in the admission of children in specialized centres and in aiding all the social problems of the patients treated at Sainte Justine Hospital.

The department is divided into five sections. The first section, which is the general service, is responsible for visits to all patients treated in public wards, including insurance cases. Visits to all other patients, for special reasons, are made upon request of the doctor in charge of the patient. Five graduate nurses are in charge of this work, one of whom is assigned to the premature service and visits the homes of these cases before and after their departure from the hospital.

The second section assures the control of all cases of B.C.G. vaccination and is under the supervision of three graduate nurses.

The third is responsible for preparing all information and requests for admission in specialized centres and is in the charge of



A conference in the medico-social department.

three graduate nurses and one secretary.

The fourth section takes care of the outdoor clinic, our obstetrical department, and the pre-natal clinic. There are two social assistants in this service, one of whom does the secretarial work. Two graduate nurses directly delegated to the obstetricians are also attached to this clinic.

The fifth and last section, composed of one social aid worker and one secretary, is attached to our orthopaedic department. In addition to these, two secretaries are used for general duty.

What are exactly the duties assigned to each and every one? The director of the department supervises and decides all medical problems: information requested concerning patients hospitalized at Sainte Justine, those who have left the hospital and still remain under treatment—all this requires considerable correspondence. The director also supplies information to social agencies, to insurance companies, to the Social Welfare Court and to other hospitals, who request medical reports on patients hospitalized or who have left the hospital, and in many cases, confirmation of demands for pension or aid.

Every morning, the director holds regular meetings with his staff to study the work done the previous day by all the personnel. He gives directions for special cases and outlines the day's assignments. Dr. Lapierre is also in charge of the post-natal clinic where patients are received twice a week, on Mondays and Thursdays, at 1.30 p.m. Two nurses of the medico-social department assist at the consultations. The assistant to the director assumes

responsibility for the daily work. Since 80 to 85 families are visited every day, the preparation of the daily program requires a considerable length of time.

Our outdoor clinic also requires the medico-social department's help and we are frequently asked to visit the homes of patients in order to verify if treatments prescribed are well understood and fulfilled. Subsequent visits are also made for further control, and the visiting nurse decides if she should continue visiting the homes.

The medico-social service has recently assumed social care of prematures. It is very important to be assured that these babies, after receiving meticulous care at Sainte Justine, should be assured of receiving the proper treatments in their homes. A nurse visits the mother before the discharge of the baby from the hospital and the discharge will be delayed if, for example, infection is found in the home. When the baby is to be returned home, the nurse will make sure that the house is comfortable and, if possible, that a single room is available. This is not always possible but satisfactory arrangements for proper care can usually be found.

In a few particular cases, when the mother, for various reasons, can not take care of her baby, the nurse will study the possibility of placing the child in a responsible home, but this is never done unless no other solution can be found.

During the first home visit, before discharge from hospital, the nurse tells the mother that visits will be made once a week during the first two weeks, then twice a

(Continued on page 128)



A youngster gets a whirlpool bath.

pour les enfants

REHABILITATION SERVICES

THE rehabilitation services were planned to answer all the needs of the handicapped child in one physical unit. Located on two floors of the west wings of the hospital, the services are centred on the physiotherapy department which has a direct entrance for the ambulances. Thus, the out-patients, covering the minimum distance, can be circulated within the services without contact with the other out-patient cases. Two elevators connect these departments with the wards to facilitate the transport of the hospitalized patients.

Physiotherapy Department

The physiotherapy department

Five authors contributed this section. Their names appear with the appropriate divisions.

has, as its main function, the treatment by physical measures of many types of motor and neuromotor disabilities. It is divided into three sections — hydrotherapy, electrotherapy and a large gymnasium. The last is a very large room with windows along three walls. This room is divided into two sections — one, where children who are awaiting treatment play under supervision; and another, where treatment is given. In the first section are tables and chairs of graduated sizes. In the middle of the treatment section is a free area where all types of mobilizing exercises are done, such as gait-training, crawling, walking with crutches or walkers and bicycling. There are three large tables along one wall which were specifically designed

for the treatment of cerebral palsy patients by the Bobath method. Wall bars, weights and pulleys are also fixed along one wall. Parallel bars, a staircase, mats and mirrors for use in posture and gait-training, complete the rehabilitation equipment. Three separate treatment rooms with one treatment table in each are available for use when quieter surroundings are required.

Two four-bed treatment rooms, separated by an entrance, make up the electrotherapy department. Each table can be curtained off, so that complete privacy is possible if required. Because all electrical equipment, such as short-wave machines, infra-red and ultra-violet lamps, is housed here, one therapist can sometimes take care



The E-shaped swimming pool.



A section of the treatment area.

of several patients at a time. All the tables may be removed from one room, and large mats put down. The room may then be used for classes of pre- and post-natal exercises (as the hospital has an obstetrical department) or for classes of remedial gymnastics.

Hydrotherapy is divided into three sections. In the first, there is an E-shaped swimming pool with three different levels — six inches, two and one half feet and five feet. These levels are joined by underwater steps. In this way, a child of almost any age can benefit from pool therapy without undue fear. The pool is filtered and the water is kept at a constant temperature.

Folding doors separate the pool from the Hubbard tanks and whirlpool bath sections. There are two Hubbard tanks with an hydraulic lift, which, by means of an overhead runway can be centred over either tank to facilitate the handling of patients who are treated on stretchers in the water. Adjoining this is the whirlpool bath section. Four arm-size baths and two leg-size ones are provided, with two treatment tables between, so that, if necessary, children can have their exercises directly after water therapy without moving them to another room. There is a wax bath for hands and feet in a small connecting room, where dressings can be changed.

In this department, we treat all types of disabilities resulting from congenital defects, disease or injury, such as anterior poliomyelitis, cerebral palsy, lower motor neurone injuries, spinal cord injuries, pre- and post-operative heart and lung cases.

As we have been fortunate enough in the past few years to have two therapists who were trained in specialized neuro-muscular techniques (such as the Bobath and Kabat techniques) we use adaptations of these techniques in our treatment—Bobath in most upper motor neurone cases, and Kabat in the lower motor neurone cases. In addition, we use varieties of all muscle re-education and rehabilitation techniques, and various physical means such as heat, water, massage and electricity.

Most treatments are done individually, since the majority of our patients require constant evaluation and observation during treatment; however, classes in remedial gymnastics are given because the



An hydraulic lift helps patients into the Hubbard tanks.

adolescent group of children often benefit from group stimulation.

In our busy occupational therapy department the emphasis is on socialization and the activities of daily living. The organization of the occupational therapy department was begun in December 1957 when one of our dual-trained therapists initiated occupational therapy with some of our patients. As of June 1958, we have had a full-time occupational therapist.

The occupational therapy department is a large room with windows opening onto a grassy court. Because it is on the ground floor, children can go out in the summer time to ride on tricycles or have other outdoor activities. In the centre of the room, there are adaptable tables for sitting activities, and standing tables in which children can learn standing balance. In one corner of the room is a basin six feet long and three feet in height, around which the children can learn standing balance while sailing their boats. This is also a wonderful means for socialization. A completely equipped bathroom with smaller size appliances and adaptations for training in activities of daily living opens off the room. Most of the cases treated in this department are cerebral palsy patients.—*O. Anich, director.*

Education Service

In the province of Quebec, education of children is divided into two departments—under the Catholic and Protestant school boards—each financed by taxes from their respective religious group. The

local school boards appoint the teachers. In our hospital, since there are very few non-Catholic patients, we have Catholic teachers only.

These teachers follow the regular program of studies inasmuch as the health and physical condition of the child allows. Each child whose hospitalization exceeds one week is expected to follow his regular course of studies, so that he will not be delayed when he returns home.

Bedside teaching and group teaching for ambulatory patients is carried out regularly with homework (or rather bedwork) and study periods when possible. This system has produced very good results so far, and few of the patients are set back in their studies because of their hospitalization.

Apart from the regular school teachers, we have a teacher specialized in retarded or handicapped children who has organized a "Jardinière d'Enfants" where these patients are trained initially by the Montessori method; then they proceed to more regular studies. This new adjunct to the education service proved a very valuable addition, and it has helped the rehabilitation services to socialize these cases, and then prepare them to fit into the special or regular classes when their physical or mental handicap is sufficiently improved.

Speech and Audiology Clinic

The speech clinic was established in 1936 for the rehabilitation of cleft palate cases. It was the first speech set-up organized as such in the province of Quebec. Today the

speech and audiology clinic has extended its services to the various types of speech pathology.

The cleft palate and articulation disorder cases are referred to the clinic as early as possible by the plastic surgeon or by the medical services after a complete investigation has been made of the child's general condition. Early counselling to parents provides them with the necessary approach for helping their child in the development of language and motivating his verbal communication. The social service makes a thorough investigation of the social problems of the family and guides the parents in coping with them. A therapeutic program is elaborated for the cleft palate cases when the child is judged ready by the surgeon. When there is a psychological implication in such cases, the child is seen by the department of psychiatry when he receives his speech therapy.

There are also many cases of stuttering. The diagnosis of such cases includes a complete study of the environment of the child at home and in school. While the child follows his therapeutic program, the speech pathologist works with the parents and assures a good contact with the school authorities if such is indicated.

The speech clinic works in close collaboration with the cerebral palsy clinic of the hospital. The speech therapy program is integrated with the other programs. While the child is still an infant, the parents receive counselling so they may help their child develop

the speech musculature and may stimulate his desire to talk. The parents are called to the speech clinic regularly, so that the child's evolution is controlled, thus enabling the adaptation of the program to his development.

Children with hearing problems are subject to a complete investigation after which the cases are studied in group conference held under the supervision of the otolaryngologist. The audiologist studies carefully the language behaviourism of the child and at the same time conditions him for audiometric testing. The speech rehabilitation of a deaf child is elaborated toward his admission to a special educational institution if necessary, and if not, to his integration in the public school system. —Gustave Gauthier, M.A., L.S.P., director.

Psychological Services

The rehabilitation of a physically handicapped child is, in fact, the restoring to society of a human capital which had become a liability. Rehabilitation marks the difference between a life of relative happiness in *self sufficiency* and a life of bitter disappointment in a state of *dependency* which becomes, as time goes by, more and more conspicuous and more demanding.

The psychologist is asked to provide a detailed analysis of the mental assets of the physically handicapped child. The analysis deals with the intellectual, emotional and social abilities of the

child. It is a well known fact that many physically handicapped children are also handicapped in their mental abilities. It is also common knowledge among the various specialists in the field of rehabilitation that a certain amount of intellectual ability is required if any success is to be expected from a rehabilitation program. A certain amount of emotional stability is also necessary whenever active co-operation from the patient is required. Intellectually and emotionally, a child should be sufficiently equipped to be capable of helping those who try to help him. That is why the psychologist is called upon to make a detailed inventory of a child's mental assets before a program of rehabilitation is decided upon.

One of the more frequent questions the psychologist is asked to answer concerns the readiness of a physically handicapped child for school work. The parents are always in a great hurry to send a child to school. If a child is faced too soon with school work, he invariably becomes antagonistic to it. A psychometric evaluation is a great help in determining whether a child is ready. Occasionally, the psychologist is called upon to help correct some specific attitudes, either on the part of the parents or on the part of the child, which may interfere with the rehabilitation program.

Here, at Ste-Justine Hospital, two kinds of psychological evaluations are made. First, there is a clinical evaluation made at the staff meeting held once a week. This evaluation is made to select those patients who can benefit from treatment. Then there is a more detailed and complete psychological evaluation for those cases who present special problems or who must be oriented for their future adult occupations. —Camille Caron, M. Ps., L. Paed., clinical psychologist.

The Ophthalmology and Dental Departments

These departments contribute to the rehabilitation services by the diagnosis and treatment of the many eye and teeth disorders that afflict the handicapped child. The main work of the ophthalmology department is carried out by the orthoptic section which handles these cases both as in- and out-

(Continued on page 114)



Busy workers in the spacious brace shop.



Emergency Department

Edmond Dubé, M.D., F.R.C.S. (C),
F.A.S.A., F.A.C.S.

PEOPLE often dream during a life-time of some wished-for goal. Sometimes it is never reached, although much effort and many long, tedious hours are spent in the search. This has not been the case at Ste-Justine Hospital. Members of our board of trustees and my colleagues on the medical staff, after working in very crowded quarters in our old hospital for many years, now occupy splendid new quarters. Many departments deserve special mention, but I have chosen to write a few well-deserved words describing our emergency service which has such an important rôle to fulfill.

One of the rapidly advancing trends which have been most noticeable during the past few years has been towards a realization of the importance of the emergency department. There is no doubt that this department is becoming more and more essential in a children's general hospital. Few people are properly informed about children's hospitals; few doctors really understand what the organization should be. The services to be rendered and the importance of a good staff on some form of full-time duty in the principal departments are not fully realized. The only difference, after all, between a general hospital for adults and a children's hospital is the age group of the patients. With few exceptions, then, children's hospitals must organize and maintain the same services one finds in an adult hospital. Therefore, the

emergency department in a children's hospital must be thoroughly and efficiently organized on a 24-hour basis in order to accommodate all the patients who may arrive at the hospital at any time, and who cannot be sent to the regular outdoor clinics.

In this hospital's emergency department, we have given special consideration to: (a) the location and necessary space, (b) the medical staff, (c) the nursing and secondary staff (such as competent aides, secretarial personnel and porters), and (d) the ambulance service.

Location and Space Available

The location of the emergency department is certainly of primary importance. The department must be easily accessible to the public, to the ambulance service, and to hospital personnel. We considered many entrances and decided that the service should be close to the street entrance, but not exposed to traffic disturbances. There must also be sufficient space to allow three or four cars to manoeuvre easily. Conditions must enable patients, especially stretcher cases, to be brought directly under shelter. All this has been amply provided for.

The space available in the department is also very important. Seven examining rooms and two operating rooms with all the necessary equipment—including oxygen and suction outlets—have been provided. One room has been allocated to our poison control centre which has been organized with the aid of the province of Quebec's Ministry of Health and which is

recognized as one of their three official centres. A monthly average of 15 to 20 patients are treated in this centre which is under the control of a paediatrician who has specialized in such work. He is often called upon to supply information to outside sources.

Staff—Medical, Nursing, and Secondary

Our emergency department receives a great many patients of all kinds. Most require surgical treatment, but there are also many medical cases, suffering from ear and throat infections, et cetera. The primary responsibility for directing the treatment of these patients rests with the regular staff on duty, but most of the initial work is done by residents and interns. We have assigned to the department two residents—one in surgery and one in medicine—who are aided by at least three interns, two of whom are always on duty in the department. They are provided with sleeping quarters immediately adjacent to the emergency rooms.

In any department, a specially trained staff is necessary; this is still more important in a children's hospital. We have, therefore, insisted on sufficient personnel. Always on duty are three attending doctors (a physician, a surgeon and a specialist), three senior interns (one surgeon and two physicians) and three junior interns (also one surgeon and two physicians). Four graduate nurses are present from 8 a.m. to 4 p.m., three from 4 p.m. to 12 a.m., and one from 12 a.m. to 8 a.m. A nursing aide is provided for each of the

Dr. Dubé, medical director, is head of the Children's Orthopaedic and Surgical Service.

three shifts, and one x-ray technician and a porter are present for two shifts—8 a.m. to 4 p.m. and 4 p.m. to 12 a.m. If such personnel can be maintained, we feel that we can give the service required to the great number of patients received in this department—about 87 a day, with the peak load between 3 p.m. and 10 p.m.

Adequate secretarial service is most necessary and should be available at all times if proper records are to be kept. These records must be comprehensible when consulted for compensation cases several weeks after the accident.

Competent aides are also of primary importance and in a children's hospital, these aides must have had previous experience in

the field. Children are easily upset, even in minor circumstances, but if they receive the proper attention and care, many unpleasant incidents and memories can be avoided.

The Ambulance Service

There is no doubt that the ambulance service must be adequate in any emergency department. We have provided for this by having one ambulance always stationed next to the service. A room is at the disposal of the chauffeur for sitting and sleeping. If the ambulance is called out, we can reach immediately a second ambulance which stands available.

Many of our patients are brought directly to the hospital by the police department in its own cars. This has proved to be a very satisfactory arrangement, since delay is thereby avoided in the transporting of patients to hospital. This means of conveyance is certainly adequate for a large number of our cases.

I have tried in this very brief description to give a general idea of our efficient emergency department, now in a position to respond to all calls which are made upon it.



Motor entrance to emergency department.



An operating room in use for an emergency.

A Premature Centre

Robert Saint-Martin, M.D.

BEFORE describing the premature unit at Ste-Justine Hospital, it is necessary to discuss briefly the importance of the problem of this special category of infants.

It is well known that prematurity constitutes the principal cause of neo-natal and infantile mortality. More infants die in the first three days of life than during the other 362 days of their first year. Although, during the past 50 years, other causes of mortality have progressively diminished due to better hygiene, the number of deaths among the premature infants has remained unchanged. It has now become urgent to take proper steps to overcome this situation.

Many countries have already outlined programs; some of which try to decrease the frequency of premature births; while others try to or-

ganize the best possible care for the premature. The City of Chicago was the first to realize such a program in 1934, and at present, in nearly every American state, local services of maternal and infant hygiene have organized programs for the prevention and care of the premature.

The establishment of special premature units in hospitals, for the treatment of premature infants, is basic to such a program. As stated by Alfred J. Vignec: "One of the most effective means of lowering our present neo-natal mortality rate lies in improving the standards of premature care. Whenever and wherever this has been possible, a significant and gratifying reduction in the premature mortality rate follows, with almost the same predictability as night follows day. It has been definitely established for some time now that the *sine qua non* of good premature care is the establishment of a premature unit in the hospital,

separate and distinct from either the newborn nurseries or the paediatric service proper. This insures fixed, skilled nursing personnel and more adequate medical supervision; it provides more space, light, ventilation, and physical equipment, and it is an aid in the better control and treatment of acquired morbidity. If the above facts are true, one may well ask why most hospitals continue to care for their prematures either in conjunction with the full term newborn nurseries or in the paediatric service, and why they do not all establish autonomous premature units. The answer, of course, is an economic one. There is no question that the construction, equipment and proper operation of a premature centre are all costly. Even more costly than the initial construction and equipment is the long-range operation of the centre. Studies in New York City (1952) indicate that the cost per infant cared for in a premature centre according to standards is approximately \$18 per day."

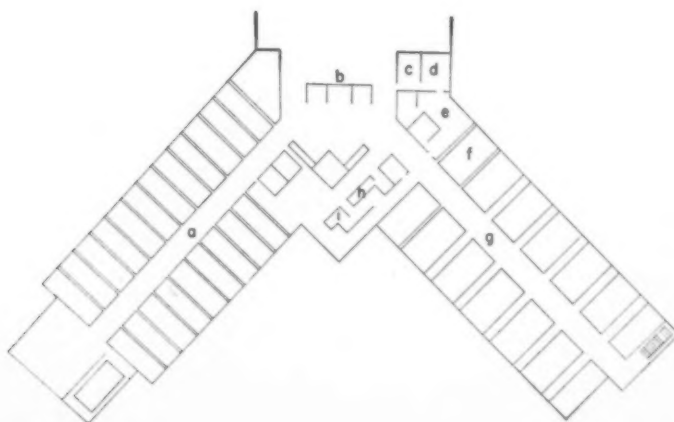
At Ste-Justine Hospital, the construction of a new children's hospital permitted the inclusion of a special premature unit—a most important service in a city like Montreal. Since 1950, we have treated approximately 450 prematures every year, two-thirds of which were born in their homes or in small private hospitals.

In the treatment of our prematures we have followed the directives of the American Academy of Paediatrics, and we have also adapted our organization along the lines of well known centres such as the New York Hospital

Dr. Saint-Martin is head of the premature department at Ste-Justine.

Plan of the Premature Department and Special Unit.

- a. special unit
- b. nurses' station
- c. waiting room
- d. doctor
- e. intern
- f. parents' demonstration room
- g. premature babies
- h. soiled unit
- i. clean unit



Cornell Medical Centre Premature Unit and the "Ecole de Puériculture de la Faculté de Médecine de Paris".

Ste-Justine's unit is depicted in the diagrams, and a few of the features call for comments. It is located on a separate and isolated floor of the west side of the building and consists of ten air-conditioned nurseries, each having a capacity of four or six infants; a nurses' station; two utility rooms and a parent teaching room containing home-type of equipment for use in demonstrations to the parents. One utility room is reserved for the storage of linen and medication used in the unit, and for the storage of formulas prepared in the central formula room. The other room is reserved for soiled used diapers, linen and feeding equipment. Two observation nurseries, each having a capacity for two infants, are also available. The air-conditioning apparatus is centrally operated and maintains a constant temperature of 78°F. and a relative humidity of 65 per cent. There are 15 changes of air per hour.

We have at our disposal, for the exclusive use of prematures, 15 incubators with humidity control, six incubators without humidity control, and 15 heated cribs.

A little over two-thirds of the prematures cared for in the unit are born outside the hospital;

some in other hospitals and others at their homes. These prematures are transported to Ste-Justine in small incubators and in our especially equipped ambulance. Prematures born outside the hospital, who have been delivered within 24 hours under sterile conditions, are admitted to the general premature nurseries. When outside delivery has occurred under doubtful conditions or if the premature is older than 24 hours, he is admitted in a special room in the proximity of the premature unit.

When the infant weighs five pounds and is progressing, the parents are invited to visit the nursery. There the mother bathes and feeds her own baby, under the supervision of a nurse in the parent teaching room. The method of terminal sterilization of the formula is taught and other instructions are given. Both parents may come as many times as necessary, until they feel confident about caring for the infant. During the afternoons spent in the nursery, numerous questions about routine care are answered for the parents.

Before discharge from the hospital is given, a special nurse visits the parents at their home so that she may be sure that the baby will receive all it requires, under normal conditions. When the baby is returned, the nurse continues her visits in order to

help the parents and to supervise the baby's care.

Upon discharge, an appointment is made for the baby to come to our follow-up clinic. There again, the nurse and doctors reassure the parents about the baby's progress and development. Prematures are checked at the follow-up clinic periodically for the first two years.

Our premature centre is recognized as a teaching centre for graduate nurses by the Division of Maternal and Infant Services of the Ministry of Health of Quebec and by the Child and Maternal Health Division of Ottawa. A two-month course for graduate nurses has been organized on their behalf.

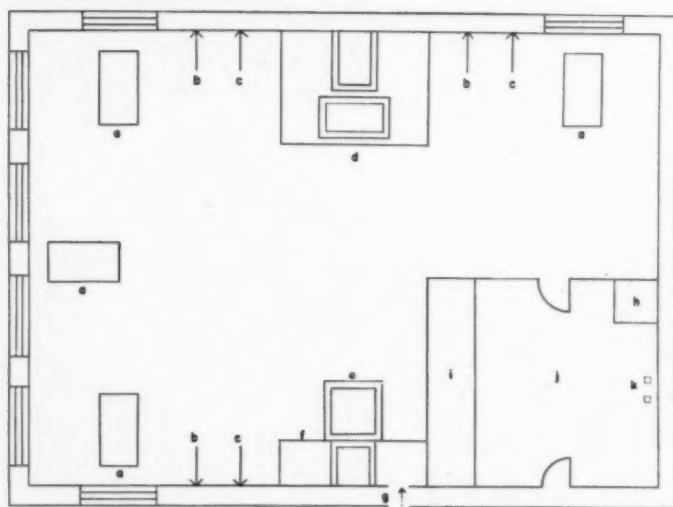
The program is conducted by a paediatrician and a nursing supervisor. The nursing supervisor devotes the major part of her time to the institutes. A wide range of subjects is covered, among which are: broad community aspects of the problem of premature birth; obstetric measures for prevention of premature birth, and planning of a hospital unit for premature babies. Other subjects discussed include: immediate care of the premature infant in the delivery room and resuscitation procedures; physiological handicaps of the baby born prematurely; his metabolism, his feeding, environmental factors in the care of premature infants; control of infections and retrolental fibroplasia. Instruction of parents is given special emphasis.

The physicians who give lectures and demonstrations include obstetricians, paediatricians with experience in public health, and paediatricians who have research or clinical experience in subjects bearing on the care of prematurely born infants, such as pathology, physiology, haematology, ophthalmology and neo-natal surgery.

Numerous demonstrations emphasize the principles for successful care of premature babies and the judgment necessary for carrying out these principles. Since the inception of our teaching program, approximately 20 graduate nurses have followed this course.

We are at present studying the possibility of organizing a program which will bring together the paediatrician and one or two graduate nurses working in the same hospital in order that they may jointly consider all problems relevant to a premature unit.

Plan of the Premature Nursery.



- a. beds
- b. suction
- c. oxygen
- d. babies' bath table
- e. sink
- f. cupboards

- g. exit for soiled linen
- h. sink
- i. writing table
- j. waiting room
- k. coat racks

La Physiologie Cardio-Pulmonaire

Emilien Labelle, M.D.

LES malformations congénitales du coeur et des gros vaisseaux ont longtemps constitué le chapitre le plus obscur, le plus décevant et partant le plus dédaigné de la cardiologie. Ces anomalies structurales ne présentaient d'intérêt que pour quelques pathologistes. Les cliniciens abdiquaient d'emblée devant ces cas incurables et l'issue fatale à plus ou moins brève échéance représentait la seule porte de sortie pour eux comme pour les patients.

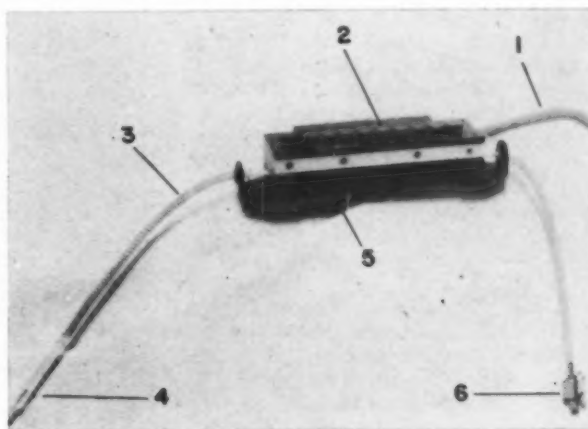
En 1929, un urologue allemand du nom de Forssmann s'avisa de démontrer la possibilité d'introduire une sonde dans le coeur en passant par une veine du bras. Il fit la manoeuvre sur lui-même avec succès. Son geste fut considéré tout au plus comme un acte de bravoure et tomba dans l'oubli pour une bonne dizaine d'années. En 1941, Cournand et Ranges partant du principe de Forssmann, développèrent la technique du cathétérisme du coeur et l'exploitèrent à fond pour l'exploration hémodynamique des cardiopathies congénitales. D'autres chercheurs s'épaulèrent aussi aux mêmes problèmes avec la même méthode: McMichaels, Richards, Stead, Dexter... Les mystères fonctionnels de tous ces syndromes apparemment disparates s'éclaircissaient progressivement, s'écludaient assez souvent pour qu'enfin on trouve des dénominations communs permettant une classification logique. Des progrès majeurs en anesthésiologie, puis des audaces heureuses d'une chirurgie en pleine conquête résultèrent en des succès opératoires qui devaient forcément attirer les regards et soulever un immense intérêt non seulement au sein du corps médical mais aussi dans le grand public. Quoi de plus spectaculaire en effet qu'une intervention chirurgicale sur le coeur lui-même, cet organe séculairement considéré

comme excessivement fragile et vraiment intouchable? Aujourd'hui, nombreuses sont les malformations susceptibles de correction. A quelques unes on ne peut offrir mieux pour le moment qu'une opération palliative—qui améliore néanmoins grandement les malades—mais de récentes réalisations rendues possibles grâce aux progrès de la dynamique des appareils cardiopulmonaires artificiels permettent 1.3 plus grands espoirs de correction éventuelle d'à peu près toutes les malformations cardio-vasculaires.

Cette merveilleuse chirurgie pour pouvoir s'appliquer réclame un diagnostic très précis. Et puisqu'il s'agit d'une chirurgie essentielle fonctionnelle, le diagnostic fonctionnel doit tendre à la plénitude. Par des corrélations qui furent établies entre les découvertes des chercheurs et les observations des cliniciens, il arrive souvent maintenant que les méthodes usuelles d'examen cardiologique (sthéto-

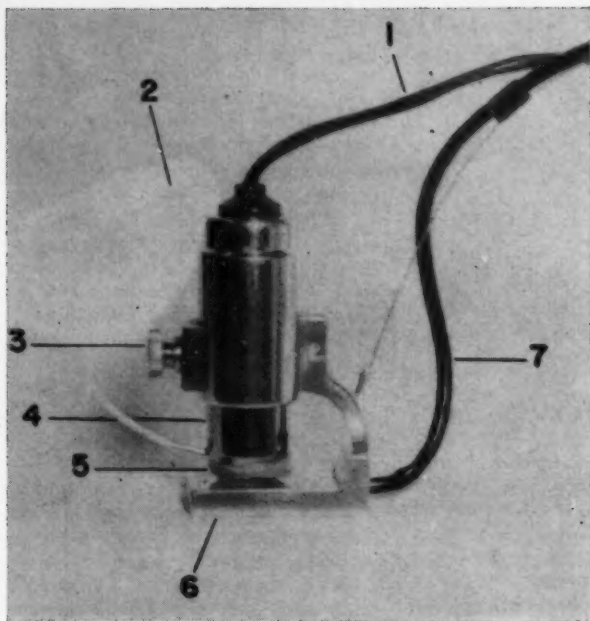
scopie, radiologie, électrocardiographie) peuvent déterminer et localiser la ou les déficiences. Mais parfois, il faut faire appel à des examens complémentaires parfois complexes. Il ne suffit pas toujours d'étiqueter la malformation ni de la localiser. Il faut pouvoir apprécier quantitativement l'importance du vice fonctionnel. Perturbation hémodynamique et monstruosité anatomique ne connaissent pas entre elles de rapport constant. Toute notre considération doit se porter sur la première, beaucoup plus que sur la seconde avec laquelle des compromis restent possibles.

Jointe aux autres procédés d'exploration clinique, l'étude hémodynamique approfondie permet de tendre à un diagnostic intégral, d'avancer sur terre ferme un pronostic opératoire, ce qui facilite l'élection des candidats à la chirurgie. Certains problèmes ne trouvent solution que par des déterminations fonctionnelles per-opératoires. Des contrôles post-opératoires permettent d'apprécier objectivement les résultats obtenus. Tous ces motifs ont inspiré aux autorités de l'Hôpital la création du Service de Physiologie Cardio-Pulmonaire. La dénomination de ce Service et la discipline qu'elle représente ne sont pas familières à beaucoup. Comment elle incorpore l'exploration des cardiopathies congénitales ne saute pas à tous les yeux. Aussi allons nous tracer rapidement la sil-



1.—Oxymètre à cuvette. Une seringue est reliée à l'adaptateur (6) et permet d'aspirer le sang dans le tube de polythène (3) au bout duquel un tube observateur (4) se joint à une aiguille ou un cathéter. Le tube de polythène est recouvert d'une source lumineuse (2). Au-dessous se trouvent les cellules photo-électriques (5) munies de filtres appropriés. Les conduites électriques (1) apportent le courant nécessaire à l'illumination et ramènent celui des cellules aux galvanomètres.

L'auteur est Chef du Service de Physiologie Cardio-Pulmonaire.



2.—Oxymètre auriculaire. Le pavillon de l'oreille s'interpose entre les cellules photo-électriques (6) et la source lumineuse (4). Cette source lumineuse est mobile pour s'adapter aux diverses épaisseurs de pavillon. Une fois en place la vis (3) permet de l'immobiliser. Une capsule de latex enrobe l'émergence de la lumière et peut se gonfler en introduisant de l'air par le petit tuyau (2); ceci pour rendre les tissus exsangués afin de calibrer l'appareil en valeurs absolues. Les fils (1) et (7) apportent le courant à la lumière et ramènent celui des éléments photo-électriques.

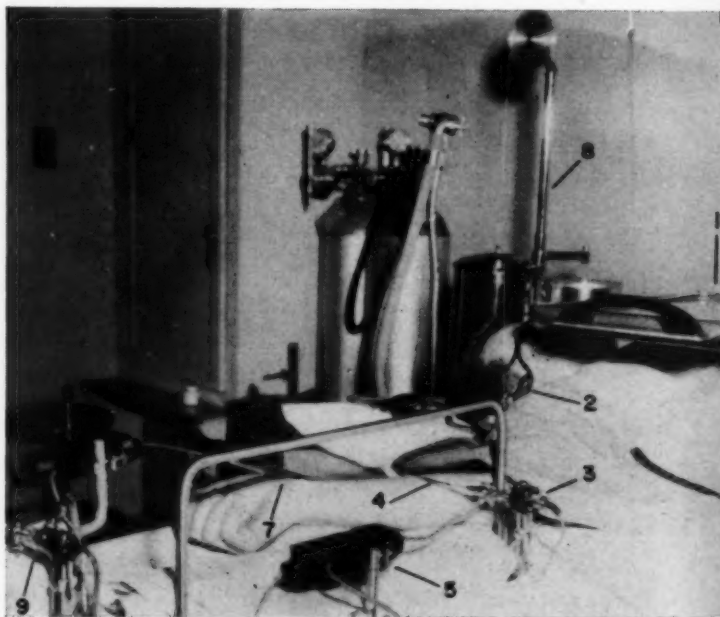
houette de ce Service, montrant du même coup comment il rejoint les angiocardio-pathies congénitales et en quoi il peut se rendre utile dans plusieurs autres cas par surcroît. Nous verrons ensuite en détails la méthode de cathétérisme cardiaque que nous employons.

Wiggers définit la respiration comme: "... l'ensemble de tous les processus par lesquels les cellules sont approvisionnées en oxygène et libérées du bioxyde de carbone produit durant la combustion."

Cette définition pose en somme les cadres de notre discipline. Ainsi, la respiration se trouve commodément segmentée en quatre grands chapitres: 1) la ventilation, 2) la diffusion, 3) la circulation, 4) le métabolisme. Chacun de ces chapitres se fragmente ensuite selon divers aspects fonctionnels pour la facilité de leur étude. D'où le grand nombre d'épreuves existantes et projetées. D'où la nécessité d'une interprétation de l'ensemble, d'une orchestration de tous les résultats obtenus en tenant compte de la partition clinique. Rappelons que ces épreuves ne constituent pas un but en soi. Ce sont des instruments de travail complémentaires aux méthodes d'investigation clinique habituelles. Ces examens ne sauraient se

substituer à une histoire de cas soignée, à une exploration somatique complète.

Deux groupes symptomatiques de patients nous sont référés: les *dyspnéiques* et les *cyanosés*. Très souvent, le malade appartient aux deux groupes simultanément, et le problème peut consister à préciser si le vice fonctionnel à l'origine de ces symptômes est pulmonaire ou cardiaque. Des troubles ventilatoires tout aussi bien que des difficultés circulatoires peuvent entraîner également dyspnée et cyanose. La dyspnée pourra provenir d'une ventilation insuffisante soit par déficience mécanique de l'appareil musculo-osseux de la cage thoracique, soit par défaut de distribution de l'air inspiré, soit par mélange intrapulmonaire imparfait des airs. L'efficacité ventilatoire étant prise en défaut, pour un temps le métabolisme tentera bien de s'habituer à ce ralenti mais ne réussira pas toujours ni pour longtemps et l'hématose insuffisante provoque l'anoxémie et sa manifestation clinique: la cyanose. D'autre part une circulation déficiente ne saurait tirer profit d'une ventilation adéquate et les mêmes anomalies apparaissent.

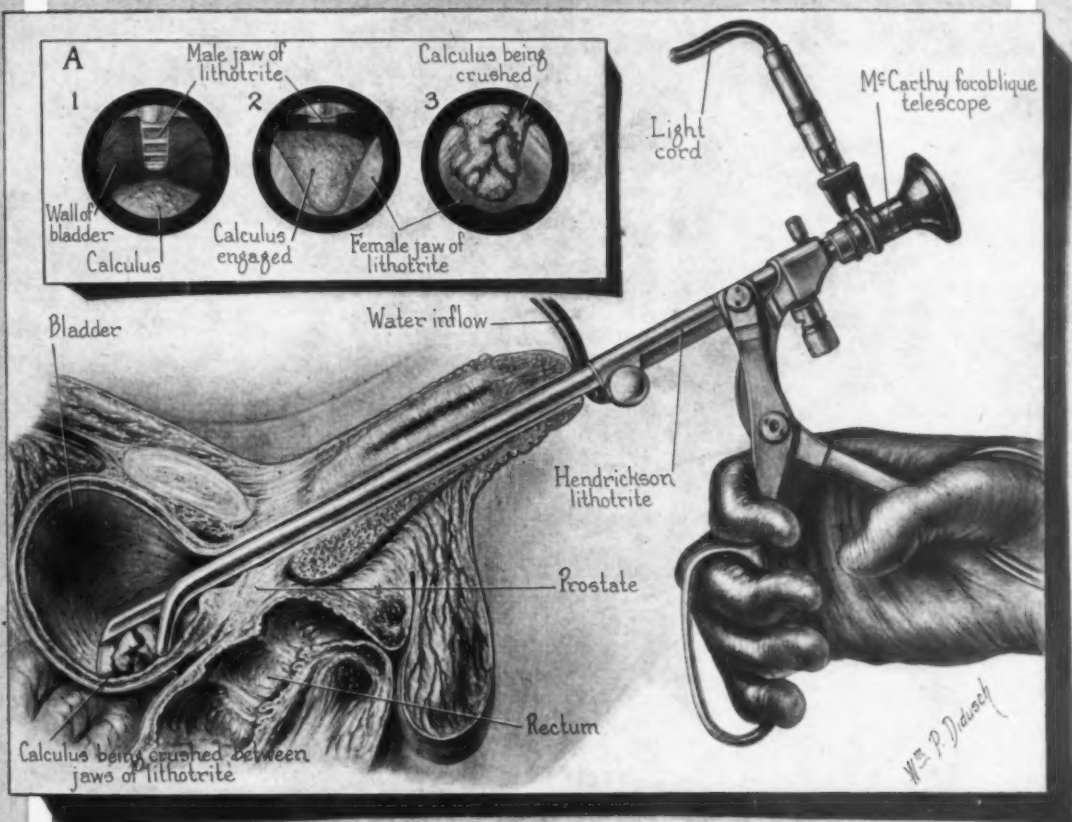


3.—Cathétérisme du cœur droit. L'écran fluoroscopique (1) permet la vision de la sonde radiopaque (4) à l'intérieur du thorax. Le cathéter est relié par un robinet à trois voies à un oxymètre à cuvette (5) et à un manomètre électrique (3). L'oxymètre auriculaire (2) permet de suivre continuellement le % de la saturation artérielle. Une aiguille artérielle (7) est également reliée à une cuvette (6) et un manomètre (9). Un spiromètre Bénédic-Roth (8) permet de mesurer la consommation d'oxygène. Tous ces appareils sont rattachés à des galvanomètres à miroirs localisés dans la chambre d'enregistrement photographique reliée à la salle de cathétérisme par un système d'intercommunication.

THE HENDRICKSON LITHOTRITE

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The illustration above shows a vesical calculus being crushed between the jaws of the Hendrickson lithotrite. Insert "A" consists of views as seen through the McCarthy foroblique telescope. 1. Shows the male jaw of the Hendrickson lithotrite behind the vesical calculus. 2. The female jaw has been pushed forward to engage the calculus. 3. Shows the calculus being crushed.

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Il ne suffit pas de bien aérer les alvéoles pour assurer des échanges gazeux adéquats. Il faut la présence d'une quantité suffisante de sang veineux à transformer. Il faut, en d'autres termes, une certaine balance entre l'apport gazeux et l'apport sanguin. Ce rapport est brisé par un shunt intra-pulmonaire tout aussi bien que par un shunt intracardiaque. Et c'est ici que les angiopathies congénitales surtout viennent perturber la fonction respiratoire. L'attention préférentielle dont nous les entourons s'explique bien.

Nous croyons que le patient chez qui une exploration fonctionnelle s'impose mérite et doit profiter de l'exploration la plus complète possible. Aussi, à titre d'exemple, la technique du cathétérisme cardiaque est-elle très élaborée chez nous. Ce déploiement d'instruments et de manoeuvres n'a rien de superflu. Tout est mis en oeuvre afin d'obtenir le maximum de renseignements, afin de prévenir les insuffisances et les sources d'erreurs possibles de méthodes plus simples. Notre méthode incorpore, en plus de la gazométrie, l'oxymétrie et les courbes de dilution dont nous allons dire un mot.

L'oxymètre, dont le principe est

analogue à celui du spectro-photomètre, permet la détermination directe et continue du pourcentage de la saturation en oxygène du sang artériel, au repos, à l'effort et durant l'administration d'oxygène à 100%, ce qui permet ordinairement de localiser soit au niveau du coeur (shunt vrai), soit au niveau des poumons (pseudo-shunt) la cause d'une faible oxygénation artérielle et de la cyanose qui en est l'expression tégumentaire. Deux modalités pratiques de la méthode s'offrent à nous: a) la méthode sanglante de la "cuvette", (fig. 1), et b) la méthode trans-cutanée (pièce auriculaire) dans laquelle le pavillon intact de l'oreille joue le rôle de la cuvette (fig. 2). On devine que si la cuvette est reliée au cathéter veineux, le pourcentage de la saturation du sang recueilli dans les cavités cardiaques visitées sera fourni instantanément. Notons qu'il s'agit de l'oxymètre de Wood donnant des valeurs absolues.

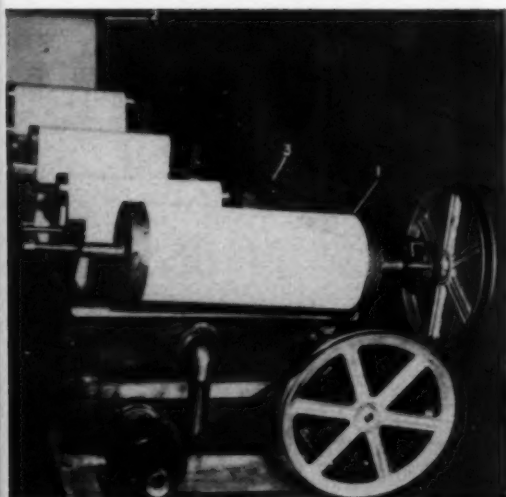
L'oxymètre réagit à la présence dans le sang de colorants tels que le bleu de méthylène et le bleu Evans (T-1824) de la même façon qu'en face d'une réduction de l'oxyhémoglobine. Si on injecte subitement une dose d'un tel colorant dans une veine périphérique—le pa-

tient respirant de l'oxygène à 100% pour assurer la stabilité de la saturation—et qu'on surveille la réponse de l'oxymètre sur le versant artériel en l'enregistrant sous forme de tracé, on verra s'inscrire une courbe dont les caractéristiques permettront: 1) de déceler la présence d'un court-circuit même minime, 2) d'en connaître la direction artério-veineuse ou veino-artérielle, 3) d'en apprécier la magnitude.

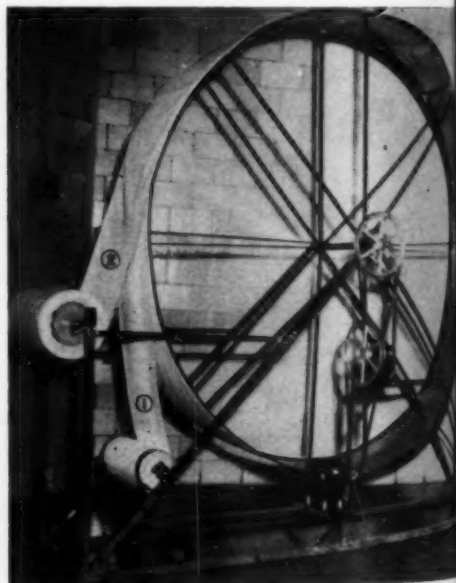
L'étage où réside le court-circuit (shunt) n'est toutefois pas révélé par une telle courbe dite "périphérique". Pour cette précision, il faut pratiquer des injections "centrales", lors d'un cathétérisme, à divers niveaux en amont et en aval du court-circuit. Ainsi, en présence d'une communication inter-auriculaire avec shuntage de droite à gauche, les courbes des veines caves et de l'oreillette droite indiqueront le shunt alors que celles du ventricule droit et de l'artère pulmonaire apparaîtront normales. De telles courbes, en plus de leur grande valeur diagnostique offrent également la possibilité de plusieurs déterminations utiles: le débit cardiaque, le volume sanguin, le temps de circulation, le temps de saturation, etc.

Lorsque les données de la gazo-

5.—Au sortir du bain, le rouleau de papier photographique mouillé est placé en (1). En (2) se trouve une bobine de coton. La roue, en tournant, étale le papier en interposant entre chaque couche un rang de coton pour favoriser l'absorption de l'eau et prévenir que le papier colle sur lui-même. Dans le nouvel immeuble, ce séchoir fera suite au bain et le papier s'y engagera dans une seule opération.



4.—Au sortir de la camera, le rouleau de papier photographique est installé sur la bobine (1), et attaché à un guide de plastique qui le déroulera en le faisant passer successivement dans le révélateur, dans un bain de rinçage, dans le fixateur, dans un autre bain de rinçage et l'enroulera enfin sur la bobine (2). La chaîne (3) reliant les deux rouleaux moteurs prévient les tensions sur le papier. Cette installation de même que le séchoir (fig. 5) ont été créés et réalisés dans les ateliers de l'hôpital.



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métrie ou de l'oxymétrie coïncident avec celles des courbes de dilution, la conviction n'est que plus ancrée. Ces méthodes se contrôlent mutuellement. Parfois, les études de dilution "parlent" alors que les deux autres restent silencieuses. Sa grande sensibilité lui donne une valeur proportionnelle.

Dans son ensemble, le cathétérisme du cœur, i.e. l'introduction d'une sonde radiopaque dans une veine périphérique et sa poussée vers les divers compartiments cardiaques et les gros vaisseaux, permet l'obtention de renseignements précieux de trois façons: 1—par l'identification d'un *trajet anormal* de la sonde (radiologie et courbes de colorants); v.g. du ventricule droit au ventricule gauche et dans l'aorte dans un cas de communication inter-ventriculaire...; 2—par la démonstration de *valeurs anormales pour le contenu en oxygène* du sang des cavités explorées, v.g. sang beaucoup plus oxygéné dans l'oreillette droite que dans les veines caves dans un cas de communication inter-auriculaire avec shunt gauche-droit; 3—par la dé-

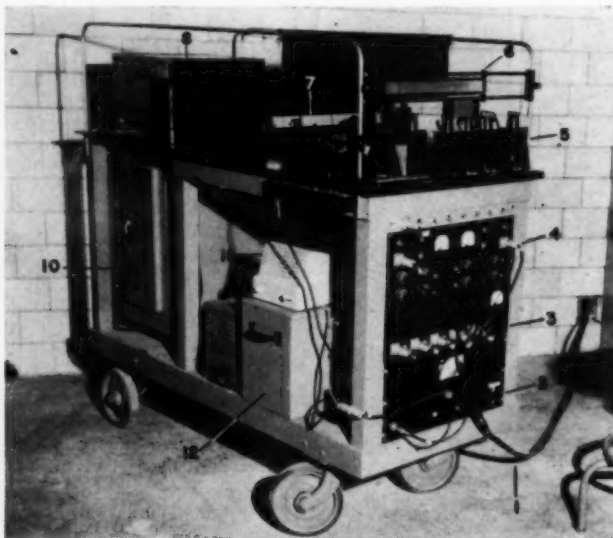
monstration d'une *différence de pression élargie* de façon significative de part et d'autre d'une valvule, v.g. entre le ventricule droit et l'artère pulmonaire, indiquant une sténose pulmonaire. Au cours de l'épreuve, la consommation d'oxygène (par minute) du patient est déterminée si on désire une valeur du débit cardiaque par le principe de Fick. Ce même débit peut également s'obtenir par calcul d'une courbe de dilution. Toutes ces déterminations peuvent être répétées soit durant un effort, soit sous l'influence de divers stress physiologiques et toutes ces données renseignent directement ou par l'intermédiaire de calculs subséquents concernant les débuts, les résistances vasculaires, etc., non seulement sur la nature et la situation de la malformation mais aussi sur sa sévérité, sur l'indication opératoire, sur les réserves fonctionnelles cardio-pulmonaires et enfin sur le pronostic.

Le cathétérisme se pratique habituellement sous simple sédation dès que l'enfant comprend suffisamment pour garder l'immobilité

relative nécessaire. Tout au cours de l'examen, dont la durée varie de deux à cinq heures selon le cas, le pourcentage de la saturation en oxygène du sang artériel est gardé à l'oeil, grâce à un oxymètre auriculaire. Le cathéter est relié, par un robinet à trois voies, à une bouteille de sérum physiologique hépariné servant à le rincer périodiquement pour prévenir la coagulation, à un manomètre électrique (de type strain gauge) et à un oxymètre à cuvette. (fig. 3). Le valeur de l'oxymètre à cuvette au cours du cathétérisme chez l'enfant ne saurait trop être soulignée. Cet appareil permet une lecture avec quelque deux ml. de sang. Si le circuit reste stérile, le sang peut être réinfusé au patient. En procédant ainsi, il nous fut possible de pratiquer vingt-sept échantillonnages veineux chez un bébé pesant six livres et demi. Le problème de la transfusion se trouve réglé.

Un circuit identique à celui du cathéter reçoit une aiguille artérielle. De cette façon, tout au cours de l'examen, le pourcentage de la saturation artérielle, la pression artérielle, la pression et le pourcentage de la saturation des diverses cavités explorées sont continuellement disponibles à l'opérateur. L'électro-cardiogramme se déploie constamment sur l'écran d'un oscilloscope, tout près de la table d'examen. Tous les appareils sont reliés à des galvanomètres à miroir placés dans une pièce voisine. L'enregistrement de toutes les variables se fait sur papier photographique de douze pouces de largeur. Les longueurs nécessaires varient de trent à deux cents pieds (fig. 4 et 5). Ce système d'enregistrement présente des avantages incontestables: grande stabilité de courant continu pendant de longues périodes de temps, vaste échelle d'amplification mécanique instantanée, inertie pratiquement nulle, etc. L'inconvénient majeur de l'inscription photographique consiste en l'impossibilité d'obtenir sur-le-champ le document nécessaire aux mesures puisqu'il faut développer le papier, le fixer et le laisser sécher. Cet inconvénient a été éliminé. Un miroir réfléchit une partie des faisceaux lumineux se dirigeant sur la lentille de la camera en direction d'un verre dépoli calibré. De cette façon, l'opérateur de la camera peut transmettre aux gens qui travaillent dans la salle de cathétérisme

(Suite à la page 116)



6.—Le "laboratoire mobile" de la salle d'enregistrements. Tous les circuits électriques afférents et efférents entre la salle de cathétérisme et la salle d'enregistrements circulent dans un gros câble isolé (1). Chaque appareil rejoint individuellement son galvanomètre (4) par le tableau de contrôle. En (4) se trouvent les oxymètres, en (3), les "strain gauges", et en (2), le cardiotachymètre et l'électrocardiographe. Les galvanomètres (5), éclairés par la source lumineuse (9) envoient leurs faisceaux sur la lentille de la camera (8). Une partie des faisceaux frappe le miroir (7) et revient sur l'écran (6) où l'opérateur voit ce qui se photographie, et grâce à une calibration pré-établie peut communiquer au cathétériseur les valeurs à demander en se servant de l'intercomm. (11). Le papier photographique se déroule dans une boîte (10) mobile qu'on transporte à la chambre noire. La plupart des instruments sont actionnés par du courant continu de bas voltage et la boîte (12) renferme les batteries à cette fin. Si l'on désire enregistrer à la lumière, on peut le faire à condition de recouvrir le dessus du chariot d'un drap.

ANOTHER CASTLE INSTALLATION STE-JUSTINE'S HOSPITAL

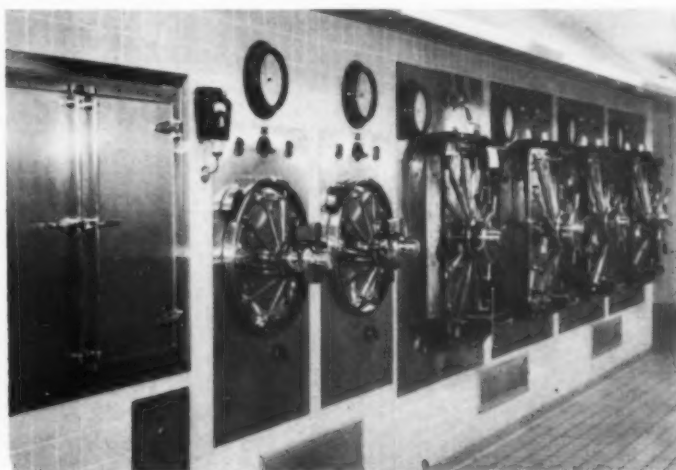


The Ste-Justine's Hospital situated on Côte Ste Catherine Road, Montreal, is a veritable showroom for the latest Wilmot Castle Equipment. We would like to express our gratitude to the architects, Joseph Sawyer and Henri S. Labelle and the consulting engineers, Leblanc and Monpetit, for their splendid planning and specification of sterilizing and lighting fixtures. Our sincere thanks to the General Contractor Damien Boileau for their untiring effort in supervising this project, and to the Electrical Contractor, Metro-pole Electric Inc., for their co-operation in solving many complex technical problems. With this spirit of unity, our task of complying with the specifications of each department was greatly minimized. Some of these departments are shown in the following photos.



Typical, one of 15 major operating rooms in this modern institution is equipped with the new Castle No. 62 Major Surgical, overhead light. The No. 62 light features the Castle exclusive internal Cam balance and electrical commutators permit repeated 360° horizontal rotation of lamphead without stops. The suspension of these lights requires no tracks or dangerous counterweights and the lights are the first designed for manoeuvre by members of the surgical team themselves.

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The Central Supply Room showing 4 rectangular and 2 cylindrical sterilizers, a Castle Dry-Air. All sterilizers are equipped with the Castle "THERMATIC" system which automatically operates all valves governing the sterilizing cycle. This permits step-saving traffic planning, greater load output, remote control supervision and guarantees uniform safety in technics.

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MEDICAL, PHARMACEUTICAL & SCIENTIFIC CENTER

Psychiatric Services

Denis Lazure, M.D.

IT IS almost ten years now since the child psychiatry out-patient clinic of Ste-Justine was established with the aid of the federal-provincial grants for mental health. But only last October, when Ste-Justine moved to its new buildings, did the clinic become physically and functionally integrated with the other medical services of the hospital. A few months later, the opening of a 12-bed in-patient unit formed another important landmark in the history of child psychiatry in Quebec.

During this long period (1948-57) of geographical isolation, there was virtually no opportunity for the hospital staff to become familiar with the concepts and techniques used in the psychiatric clinic. At the same time, the psychiatrists had little chance to come in contact with the psychological problems that the paediatricians have to cope with in their daily contact with sick children.

Staff: The professional staff of the clinic, also responsible for service to the in-patient department, is composed of four psychiatrists, two of whom are certified by the American Association of Psychiatric Clinics for Children. One psychiatrist is a training psychoanalyst in the Canadian Psychoanalytical Society, and the others are in or expect to begin soon psychoanalytical training. The director is serving full-time.

Our psychology section is headed by a person who has been associated with the clinic since its foundation; he is now assisted by two child psychologists—all three work full-time. A highly experienced worker is also in charge of the social service section, which comprises two other psychiatric social workers.

Dr. Lazure is director of the department of child psychiatry.

Out-patient clinic: From the beginning, the approach used by the clinic has been essentially the same as that developed by the child guidance clinics in the U.S.A. It consists in having three disciplines—psychiatry, psychology and social work—jointly studying the child-patient and his family. The findings of the psychiatric examination, the psychological testing and the psychiatric social history are discussed during a "team conference" and, once a diagnostic formulation is made, a treatment plan is drawn up which is then presented to the parents by the social worker or the psychiatrist.

In most cases, we are dealing with a child whose symptoms result from a disturbed parent-child relationship. It is therefore logical that if psychotherapy is going to effect positive changes in the child, it has to involve the parents. Usually, the child has one weekly psychotherapy session with the psychiatrist while the social worker meets with the mother, and at times, with the father. This approach can be successful only if the psychiatrist and social worker remain in frequent contact and share their increasing knowledge of the family dynamics throughout the therapy.

Most of the cases referred for out-patient therapy come from the various clinics within the hospital. In order of decreasing frequency, are the patients sent by paediatricians and other physicians, by the social agencies, the schools, the juvenile court, and finally a fair number of self-referrals.

As to the psychopathology, neurotic problems come first: they are manifested in learning difficulties, in behaviour disorders, or in anxiety-symptoms such as phobias and obsessions.

In puberty-children and in adolescents, we are often confronted

with severe pathology: the so-called borderline cases and the frankly psychotic ones. The treatment of these patients on an out-patient basis is often unsatisfactory, either because of the lack of motivation in the adolescent or because of the more intensive attention this illness requires. In those instances, in-patient care for several weeks may prove beneficial to initiate the relationship with the therapist.

The small number of pre-school children whom we see are generally difficult diagnostic problems: most commonly, it is a matter of differentiating between an early psychotic process (e.g. early infantile autism) and a condition of mental deficiency. The former entity can easily be mistaken for a primary mental retardation and even with an adequate developmental history, prolonged observation of the child may be required to clarify the diagnosis.


Finally, the clinic also provides its services to children who do not seem to be endowed with sufficient intelligence to succeed in the regular school classes. Children who are found to be genuinely retarded are directed to the appropriate institutions. Such places are unfortunately too few; and there is a pathetic need, in Quebec, for schools that would specialize in helping the mentally retarded, but educable children.

The bulk of the patient population in the out-patient department belongs to the six to twelve year-old category; next come the adolescents (12 to 16) and lastly, the pre-school group.

The average length of therapy time is six months. Most of the patients are treated by a psychiatrist, but in some cases a child may be treated by a psychologist or a social worker with the psychiatrist supervising the case. At present 80 children are undergoing therapy.

For the past six months, Ste-Justine has been conducting a program of group psychotherapy: so far there have been three groups of adolescents meeting once a week for an hour and a half. We are experimenting with various techniques—all basically Freudian. One group of young adolescent girls is being conducted along the lines of orthodox group analysis with the most encouraging results.

The other groups have been submitted to a more directive approach, with much less emphasis on

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the discussion of unconscious conflicts and defences;—these groups have shown more resistance to therapeutic changes.

We intend to broaden this new program; e.g., one of our psychiatrists is now selecting a group of pre-puberty boys with whom sessions of psychodrama will be held. This method of psychotherapy consists of encouraging the patients to act out within a certain structure (the drama model) their emotional conflicts. Topics illustrative of family or social interaction are chosen by the children and, at times, suggested by the therapist. The patients distribute rôles among themselves; the mere ventilation of highly charged feelings has therapeutic value, especially if it is supplemented with pertinent interpretations from the therapist.

In the individual therapy, the younger the child is, the more play will replace language as a means of communicating his feelings to the therapist, and with continued observation the latter will gradually recognize patterns of emotional reactions in the patient. Attention is focused on the pathological ones and interpretations are made of their origin and their effects on the child's total behaviour. We believe that children with emotional problems can improve through a so-called "relationship-therapy" in which the mechanism of identification with a relatively "normal" adult plays the main part. But it is often necessary to attempt an "insight-therapy" in the form of educative comments and interpretations of the unconsciously-motivated abnormalities in the behaviour of the child.

In-patient unit: With the creation of its 12-bed psychiatric department last year, Ste-Justine became a pioneer in the treatment of emotionally disturbed children by methods which are almost entirely psychological. Indeed, ours is the only facility of this kind for the whole province of Quebec, and needless to say, we are facing many kinds of problems. The most disagreeable one is that we cannot, at the present, provide care for all the children who need it.

We have, so far, accepted patients as young as three years and as old as fifteen, but our brief experience has demonstrated that in our present setting it is unwise to admit children over twelve.

The in-patient unit is semi-detached from the other hospital

wards: it has three rooms with four beds in each. The ratio of boys to girls has been approximately two to one. At the end of the corridor there is a large day room which is used both as dining room and recreation area. We have been using the facilities of the hospital's occupational therapy department, far removed from our area, but it is hoped that we will soon have similar facilities within our own unit. Individual play therapy sessions have to be conducted in the out-patient department, eight storeys below, a situation which also needs to be altered.

The immediate care of the hospitalized children is provided by two psychiatric nurses and two aides, one female and one male. Also one junior intern spends two months in the department, as part of his rotation.

In serving such a large paediatric population, our unit cannot be geared, on the whole, to long-term treatment. The average stay in the department during the first six months has been about six weeks. However, we do keep a small percentage of carefully selected patients for several months.

Our main objectives in admitting a child to our in-patient department are: to clarify a complex diagnostic problem through prolonged and intensive observation; to initiate psychotherapy on a daily basis with a patient who needs more in the early stage than he would have in the weekly sessions in the clinic; and to remove a child from a pathological environment, thereby frequently bringing about a spectacular improvement of the symptoms.

There are also the psychiatric emergencies commonly found in children: acute hysterical dissociation states or fugues; extreme hyperactivity and destructive behaviour, and schizophrenic reactions.

Not all the patients receive intensive psychotherapy: for many, the "milieu therapy" which we try to provide by establishing a climate of understanding and receptiveness is quite sufficient. The personnel is guided by the psychiatrists in the difficult art of providing new, corrective emotional experiences for the child whenever he relates to an adult in the department.

Psychiatric consultations are often requested for children of other departments presenting such prob-

lems as ulcerative colitis, hysterical deafness, hysterical paraplegia, psychogenic constipation, as well as the so-called behaviour disorders.

There are many situations where the collaboration of the psychiatrist and the paediatrician or the surgeon can avoid, for a particularly sensitive child, the complications of a psychic trauma associated with a medical or surgical procedure.

Psychiatry is known to evoke some resistance, conscious or unconscious, in most people who are exposed to it, either as an initial reaction or as a character trait. This resistance, I am happy to say, is minimal in the medical staff of the hospital but quite pronounced in non-medical personnel. And here lies a tremendous task of education in which psychiatrically-oriented paediatricians can play a major rôle.

Training & research: Our department is at present accredited for one year of residency training in child psychiatry by the Royal College of Physicians of Canada and we will offer a training program on that level in 1959.

Medical students of the Université de Montréal come to Ste-Justine to receive their teaching in child psychiatry and one intern is attached to the department. The School of Social Work of the same university also sends its students for training; and we have too a program for intern-psychologists.

At the moment, our staff is very inadequate in number to cope with the increasing demand for psychiatric services to children. There are now 300 patients who have applied to our clinic for treatment and who must remain on our waiting list for several months. Until this situation is remedied, we cannot spend much time in formal research projects, but we envisage for the future a multi-discipline study of the mother-child relationship which would take advantage of the unusual opportunity of having in our hospital a large maternity ward with pre and post-natal care clinics.

It is hoped that such a study would throw some light on the etiology of psychiatric disorders in children and thereby enable the medical profession to contribute to the prevention of pathological parent-child relationships, thus coming to the rescue of the too few and too overworked child psychiatrists.

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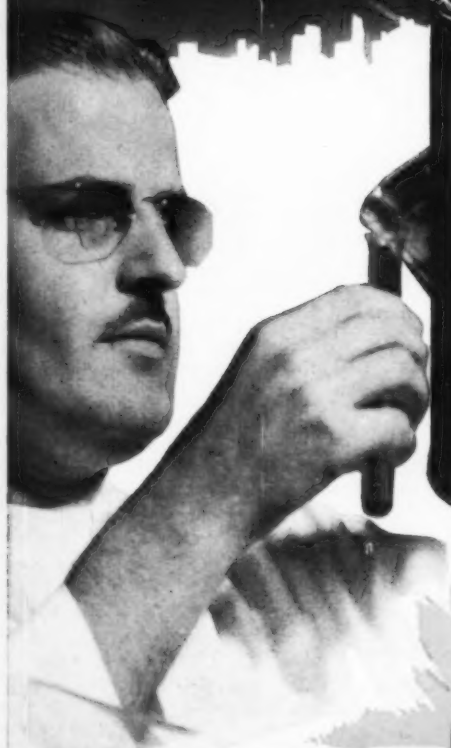
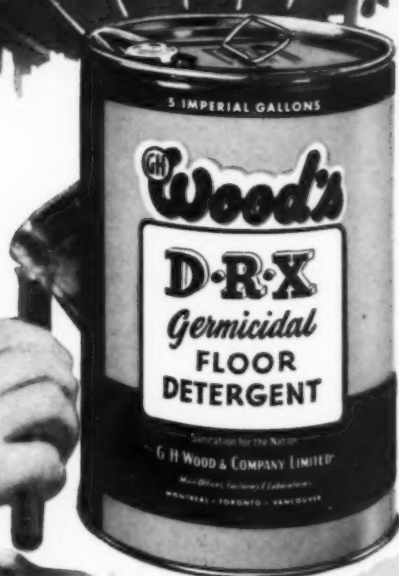
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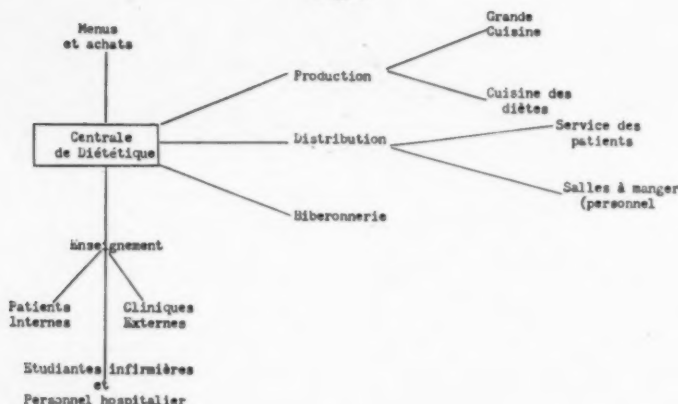
LE SERVICE ALIMENTAIRE

Sr. Claire du S. Sacrement, B.Sc.N.

LE SERVICE alimentaire se compose des différentes sections indiquées sur la figure 1. La responsabilité de chacune des sections est confiée à une Diététiste Profes-

sionnelle, qui assistée de ses aides, en assure le bon fonctionnement et s'efforce de donner un rendement maximum.

Fig. 1



La division des sections

C'est la *Centrale de Diététique* qui a la direction globale de toutes les sections. La directrice du Service Alimentaire donne ses directives après les avoir élaborées et discutées avec ses Diététistes responsables, afin que le tout soit fait avec impartialité et dans le but de faire le plus de bien possible.

Menus et Achats: Pour ce qui regarde les patients, quatre séries d'une semaine de menus, avec choix, ont été faits en vue de satisfaire le patient et de faciliter le service. Les menus réguliers sont blancs tandis que ceux des diètes spéciales sont de couleurs afin d'attirer l'attention pour que l'exécution soit faite minutieusement. Les menus du Personnel sont élaborés une semaine à l'avance et c'est d'après ces deux catégories de menus que se préparent les achats de marchandises périssables. Pour ce qui regarde les marchandises non périssables, l'inventaire perpétuel nous tient au courant du con-

tenu des réserves, et nous indique le moment propice pour renouveler le quota. Tous les matins il y a livraison de marchandises de la grande réserve à la réserve journalière de la grande cuisine pour la réalisation des menus.

Production: La superficie de la production et de la distribution est de 14,000 pieds carrés. Ceci inclut la grande cuisine, la cuisine des diètes, la préparation des plateaux des patients et la centralisation du lavage de la vaisselle de tous les malades.

La grande cuisine comprend les glaciers dont chacune est munie d'un congélateur qui nous permet de recevoir toutes les sortes de marchandises en quantité suffisante sans avoir à craindre la détérioration. Vient ensuite la boucherie ou

des milliers de livres de viande sont débitées, tranchées et préparées en vue de la cuisson; la préparation des légumes, des salades froides, la cuisson en général incluant les desserts et les pâtisseries. L'équipement tout en acier inoxydable est amplement suffisant pour nous permettre de préparer 6,000 repas par jour.

La cuisine des diètes s'occupe de la préparation des régimes spéciaux tels que calculés pour les diabétiques, hypograisseeux, hyposodés, sans résidus, de même que les gavages qui sont donnés à ceux qui pour une raison particulière, ne peuvent pas s'alimenter par voie buccale. La cuisine des diètes occupe une très petite partie de la superficie puisque son travail est de beaucoup simplifié par la production que lui fournit la grande cuisine.

Distribution: La distribution se divise en deux: a) La distribution aux patients, et b) la distribution aux salles à manger.

Les deux distributions se font en sens inverse de façon à ne pas se rencontrer.

Aux patients: La préparation des plateaux se fait au moyen d'une double courroie, côté froid pour le plateau et la partie froide du repas, côté chaud pour la partie chaude c'est-à-dire soupe et plat de résistance. (Voir photo).

Les aliments sont introduits dans des chariots contenant une section chauffée, une section réfrigérée et sur le dessus deux thermos que l'on peut utiliser indifféremment pour les breuvages chauds ou froids. Puis les chariots sont dirigés vers les étages où la distribution se fait à la porte de la chambre du patient.

Aux salles à manger: Les chariots servant au transport des aliments aux salles à manger sont des tables chaudes roulantes chauffées à l'électricité. Elles servent à alimenter deux salles à manger ou cafétérias dont les capacités sont de 250 personnes à la fois dans l'une, et 125 personnes dans l'autre. Chacun des membres du personnel se sert au comptoir et après que son repas est fini, il dépose son plateau sur une courroie automatique qui le transporte à l'unité de lavage, située entre les deux salles à manger, où la vaisselle est nettoyée, lavée et mise en place.

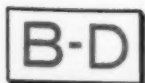
Biberonnerie: (Formula room)
La biberonnerie constitue une
(Suite à la page 68)

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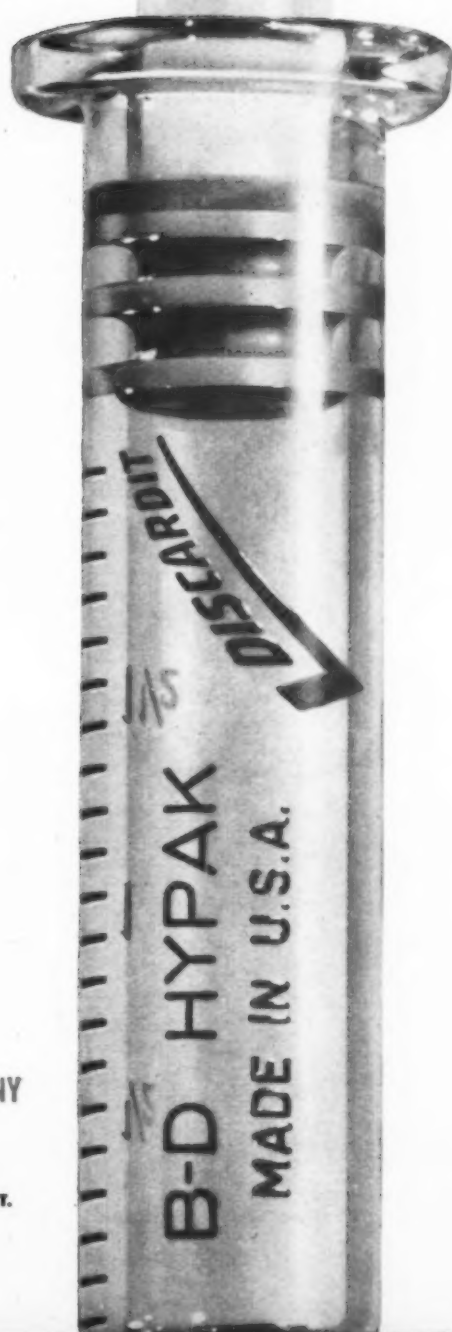
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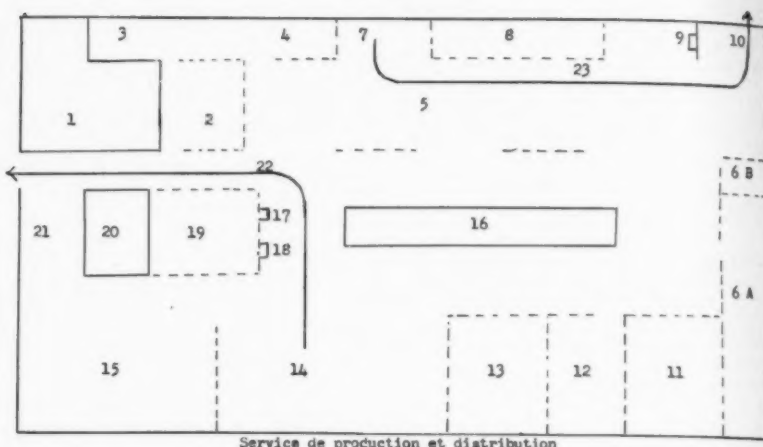


product



Clef—Key

1. Les glacières
2. La boucherie
3. La préparation des légumes
4. La préparation des salades
5. La cuisson
- 6a La pâtisserie
- 6b La glacière de la pâtisserie
7. La remise des chariots pour le transport des aliments aux salles à manger.
8. Le lavage des chaudrons de la cuisine
9. Le monte-charge (freight)
10. La sortie vers les salles à manger
11. La cuisine des diètes
12. Le bureau de la diététiste
13. La préparation des sandwiches, rôties, etc.
14. La remise des chariots pour le transport des aliments des patients
15. Le lavage de vaisselle des patients
16. La préparation des plateaux (courroie)
17. Les urnes (eau bouillante)
18. La boîte à glace (ice)
19. La section des portions
20. La réserve journalière (daily stores)
21. Unité de ménage



22. Direction des chariots vers les patients.
23. Direction des tables chaudes roulantes vers les salles à

manger.

N.B. Les lignes pointillées indiquent la présence d'un demi-mur.—The dotted lines indicate half walls.

Le Service Alimentaire

(Suite de la page 66)

partie très importante du service alimentaire dans un hôpital d'enfants. Ceci à cause du nombre considérable de nouveaux-nés et de petits malades qui y trouvent leur principale source d'alimentation. De 250 à 350 jeunes enfants reçoivent un nombre déterminé de biberons par jour selon les besoins. Une grande quantité de formules y sont préparées, par un procédé qui demande très peu de manipulations

afin d'éviter autant qu'il se peut toutes les possibilités de contamination. L'équipement est suffisant pour assurer la préparation d'au moins 2,000 biberons par jour. La stérilisation terminale étant faite, les biberons sont placés dans des glacières d'où ils sont retirés au moment voulu pour être chauffés et distribués dans les unités. Là ils deviennent la responsabilité de l'infirmière, car c'est sous sa surveillance que s'alimentent les tout petits.

Enseignement: L'enseignement se fait: a) aux patients internes ou hospitalisés, b) aux patients dans les cliniques externes, et c) aux étudiantes infirmières et personnel hospitalier.

Aux patients hospitalisés: Dès que le médecin a prescrit une diète spéciale, la diététiste chargée de l'enseignement se met en contact avec le patient pour lui donner les explications et lui faire comprendre l'importance de bien suivre ses directives. De plus ses instructions sont aussi données aux parents puisque ceux-ci jouent un rôle primordial dans l'alimentation de leurs enfants. Quant il s'agit d'un diabétique, plusieurs rencontres sont organisées avec les parents afin de bien s'assurer qu'à la sortie du patient de l'hôpital, parents et enfants (quand l'âge le permet) soient bien au courant de tous les menus détails concernant la diète et qu'ils aient en mains tout ce qu'il faut pour bien l'exécuter, sinon ils sont dirigés vers le service social de l'hôpital qui voit à leur procurer le nécessaire. Avant de quitter l'hôpital, les jeunes mamans reçoivent des instructions et démonstrations sur la façon de préparer et stériliser la formule de lait pour leur nouveau-né, de même que quelques conseils sur les additions à la diète dans les mois qui vont suivre.

(Suite à la page 70)



Distribution aux patients (la double courroie et les chariots)—distribution to patients, featuring the double belt.



LARGEST CHILDREN'S HOSPITAL IN NORTH AMERICA USES MEALS-ON-WHEELS SYSTEM

Described as a "Masterpiece of Planning," the new Ste. Justine Hospital has 860 beds and 70 bassinets served by Modern, Streamlined Central Kitchen.

From the helicopter port on its roof to the sparkling stainless steel equipment of the single kitchen on the ground floor, the new Sainte Justine Hospital for Children in Montreal is a masterpiece of planning for the utmost in patient care and comfort.

The hospital kitchen typifies this design mastery throughout Ste. Justine's, and here, aiding mightily in serving tasty nutritious meals to the "small-fry" patients (infants to 16-year-olds—plus 70 maternity patients) is the Meals-on-Wheels System. The complete hot and cold food serving system is used throughout the hospital, and the arrival on the various floors of the fleet of Meals-on-Wheels delivery carts always means happier mealtimes—just right foods for the bed patient.

Basic Planning Important

Some 6,000 meals a day can be prepared in and served from the streamlined, ventilated kitchen, and on dependable schedules, with minimum effort and cost. But this model of top efficiency didn't just happen, of course. Long before the actual planning of the hospital, research and experimenting with hot and cold carts had been done by the Dietetic staff in the old building. Institutional Kitchen specialists recommended the use of Meals-on-Wheels System to assure the most advantageous operation procedure possible. This outstanding achievement in planning a highly efficient kitchen and food service for Ste-Justine was attained through the cooperation of the Hospital representatives, Hospital Consultants, and the Counselors from Kitchen Specialties Inc. of Montreal.

This careful "Basic Planning," which is just one of the main exclusive features of the Meals-on-Wheels System, is responsible to a great degree for the many new ideas incorporated into this centralized food service—ideas that save time, space and man-hours. Ste. Justine Hospital, the largest children's hospital in North America, chose the Meals-on-Wheels System, not only for greater economy and exemplary service today, but for many years to come.

Important in the System are the men who serve you directly—your Meals-on-Wheels representatives in Canada listed below. These representatives are factory-trained in installation and servicing, and they can help train your staff in use of the simple-to-operate Meals-on-Wheels delivery units—help plan personnel assignments, work simplification, and kitchen work flow. Whether you have 20 or 1,000 beds the Meals-on-Wheels counselor can show you how you, too, can have Meals-on-Wheels System efficiency and economy. Inquire today.

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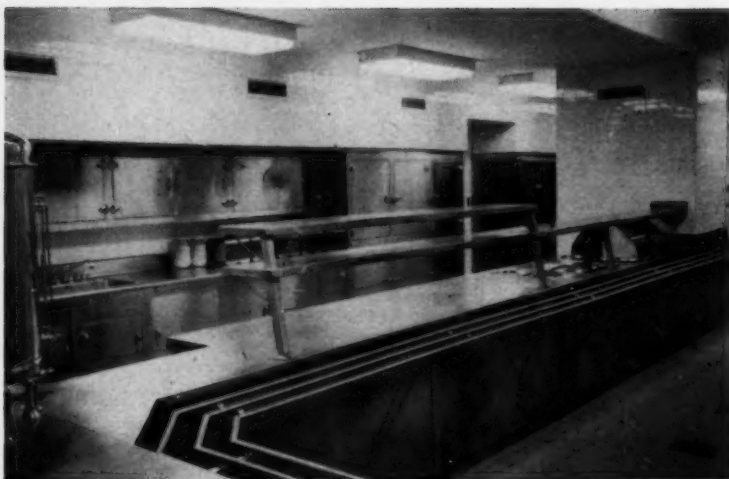
A section of the 15,000 sq. ft. central kitchen. Gleaming fleet of Meals-on-Wheels System delivery units is ready for timetabled feeding schedule. Each unit delivers from 20 to 40 complete hot-and-cold meals.



Here, tasty hot and cold foods are placed in automatically heated and refrigerated Meals-on-Wheels units. Appetizing taste and "just right" temperatures are retained until all patients are served.



Ste. Justine Hospital, largest children's hospital in North America, equipped to serve 6,000 meals daily. All patients are served through the fast, accurate Meals-on-Wheels System.



*Distribution aux salles à manger (le comptoir de la grande salle à manger)
—the large cafeteria counter*

Le Service Alimentaire

(Suite de la page 68)

Aux patients dans les cliniques externes: Ces mêmes patients, une fois sortis de l'hôpital, sont suivis pendant un certain temps dans les cliniques externes. Plusieurs d'entre eux, comme les diabétiques et les obèses, doivent s'y présenter périodiquement. La diététiste continue de veiller sur leur alimentation et leur donne au besoin tous les conseils et renseignements qui peuvent leur être utiles. De plus elle a son local près des locaux des médecins des cliniques externes et tous les problèmes de nutrition sont dirigés vers elle. Elle a de multiples moyens à sa disposition pour aider les patients à résoudre leurs difficultés alimentaires, quel qu'en soit l'origine, en ayant recours à la collaboration de plusieurs groupes organisés dans l'hôpital.

Aux Etudiantes Infirmières et

Personnel Hospitalier: Des cours de nutrition normale et de diétothérapie, avec travaux pratiques correspondants, sont donnés aux étudiantes infirmières afin de les aider à comprendre les besoins de leurs patients. Il faut les amener à reconnaître l'importance du rôle que joue une alimentation bien équilibrée dans le bon fonctionnement physiologique d'un individu. Il doit exister une collaboration étroite entre le médecin, l'infirmière et la diététiste; c'est pourquoi des causeries ou conférences sont données non seulement aux étudiantes infirmières mais aux infirmières diplômées et médecins internes. Ces causeries sont suivies de discussions qui ont pour but de résoudre les petits problèmes ou malentendus qui peuvent exister et d'amener les différents groupes du corps professionnel de l'hôpital à collaborer et parler le même

langage pour le plus grand bien de nos petits malades.

* * *

THE dietary department includes the following sections: central dietary office, from which stem menus and purchases; production in both the general and diet kitchens; distribution to the patients and to the staff dining rooms; the formula room; and the education department which takes in the in-patients, out-patient clinics, student nurses and hospital personnel.

The responsibility for each section is entrusted to a professional dietitian who, with her helpers, assures good operation and strives for the maximum efficiency.

Sections

The central dietary office assumes the general direction of all the sections. The head of the dietary department gives her directions after having worked them out and discussed them with her responsible dietitians.

Menus and purchases: Insofar as the patients are concerned, four series of weekly selective menus are made out, not only to satisfy the patient but to facilitate serving the food. Regular menus are on white paper, while the special diet menus are printed on coloured paper—these are eye-catching and so provoke immediate attention. Personnel menus are made a week in advance, and it is from these two categories of menus that the perishable food purchases are prepared. With non-perishable goods, the perpetual inventory keeps the department informed of the supplies in stock, and shows us when a renewal is propitious. Every morning supplies are delivered from the general stores to the daily store of the main kitchen in accordance with the menus.

Production: This area covers 14,000 square feet, and includes the main kitchen, the diet kitchen, the space used for preparing the trays and a central dishwashing area.

The main kitchen includes the refrigerators, each with a freezer. Thus we can keep a sufficient quantity of every kind of goods on hand without fearing that the goods will deteriorate. Next is the butcher's workshop where thousands of pounds of meat are cut up, sliced and prepared for cooking. Preparation areas for vegetables, cold salads, and general

(Concluded on page 74)



Production—la boucherie—butcher shop





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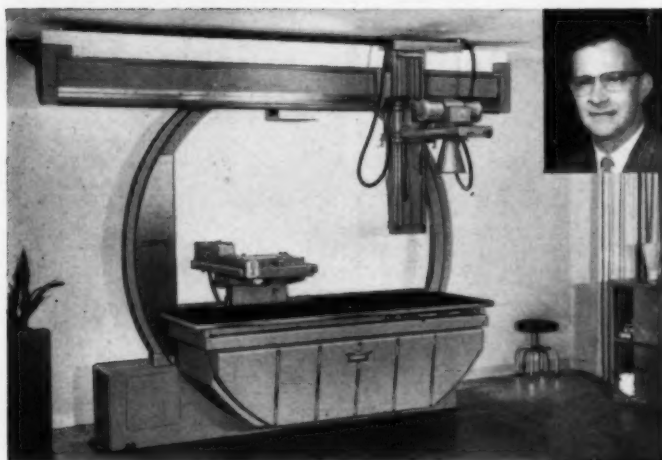
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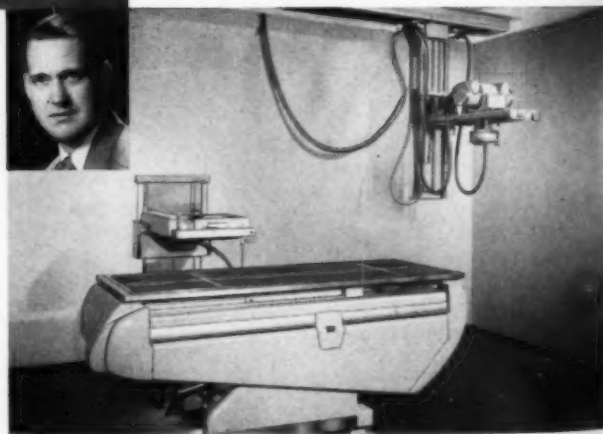


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"I call the Aristocrat a *lot* of x-ray equipment for the price," says J. W. Heller, Topeka, Kan. "I often recommend its economy for both private and hospital practice — who can match it? Full diagnostic range... 15° Trendelenburg table... overhead tube hanger... automatic spot-film device... sealed spot-film phototimer. Aristocrat has the features radiologists need! They like the full-size table too... aren't forced to shove patients into freak positions. Of course, they also appreciate the backing of traditional General Electric cooperation when they need to call on us."

THE PATRICIAN

"The Patrician's low cost comes as a big surprise to many radiologists," says T. B. Moore, El Paso, Texas. "... Makes it easy for me to fit a new G-E unit into the most modest budget. And here's a natural where hospitals want to increase patient-handling capacity. Just as low-cost autos encouraged two-car families, the Patrician makes it really practical to add an extra x-ray unit. Look at what it offers — full-size table... independent tube stand... rotating anode tube... fluoroscopic screen or spot-film unit. With 200-ma power, it can be purchased at a price that makes it foolish to settle for less!"



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St-Justine's Diet Dept.

(Concluded from page 70)

cooking (including desserts and pastry) follow. The equipment is entirely of stainless steel and is amply sufficient for the preparation of 6,000 meals daily.

The diet kitchen takes care of the preparation of special diets worked out for the diabetics, overweights, low sodium cases, and patients needing low residue diets, as well as arranging for the forced feeding foods which are given to those who cannot be fed orally. The diet kitchen occupies a very small part of the area, as its work is much simplified by the production done in the main kitchen.

Distribution: The distribution is divided into two parts: (a) to patients; (b) to the dining rooms. The distribution trucks take opposite routes out of the kitchen so that the traffic does not conflict.

The patients' trays go down one side of a double belt—and the cold food items are placed on them. At the same time the hot plates (soups and main dishes) are conveyed down the other side of the belt. At the end, the trays are placed into a refrigerated section in the truck; the hot food is placed into heated drawers assigned to each patient. On top of the truck are two thermos containers which can be used for either hot or cold beverages. The trucks are then sent to the various floors, where the hot part of the patient's meal is put on his tray, and delivered to him.

The trucks used to transport the food to the dining rooms are electrically heated. They are used to supply two dining rooms, or cafeterias—one seats 250 people, the other 125. Each staff member helps himself at the self-serve counter, and after finishing his meal, puts his tray upon an automatic belt which carries it to the dishwashing unit, located between the two dining rooms. Here the dishes are cleaned, washed and tidied away.

Formula Room: In a children's hospital, of course, the formula room is a very important part of the dietary department, since there is such a large number of newborn infants and sick children who depend on formulas for their main nourishment. From 250 to 350 youngsters receive a given number of feeding bottles daily. A large quantity of formulas is prepared in the formula room by a process which requires very little handling of bottles. This avoids, as much as possible, any contamination. The



Production—l'unité de cuisson à la vapeur—steam cooking equipment

equipment is sufficient to allow the preparation of at least 2,000 feeding bottles daily. After the final sterilization, the bottles are placed into refrigerators from which they are taken when they are needed. They are heated and distributed to the units. Here they come under the nurse's responsibility, and the infants are fed under her supervision.

Education: Dietary information is given to in-patients, out-patients and to student nurses and staff.

In-patients: As soon as the doctor prescribes a special diet, the dietitian in charge of education gets in touch with the patient to explain and make him understand the importance of following the directions exactly. Also her instructions are given to parents, as they, of course, play a principal part in their children's feeding. When a diabetic is involved, several meetings are arranged with the parents in order to make certain that, when the patient is discharged from the hospital, the parents, patient, and other children in the family are well aware of all the small details concerning the diet, and that the family has everything necessary to follow the diet satisfactorily. If the parents cannot supply the necessary equipment, they are sent to the social service department of the hospital which will procure what is needed.

Before leaving the hospital, the young mother is given directions and demonstration on how to prepare and sterilize her newborn's formula. She is also given advice on any additions which should be

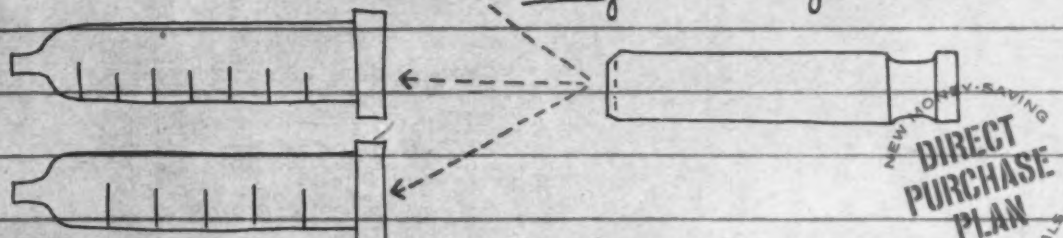
made to the baby's diet in the following months.

Outside clinic patients: After being discharged from the hospital, former in-patients often attend the out-patient clinics. Many of them, such as the diabetic and obese patients, have to call at the hospital periodically. The dietitian here keeps watch on their diets, and gives them any advice or information that might be useful to them. Her office is located near those occupied by the clinic doctors, and all nutrition problems are sent to her. She has many means at her disposal for helping patients solve their dietary difficulties. She can expect, too, the co-operation of several organized groups from within.

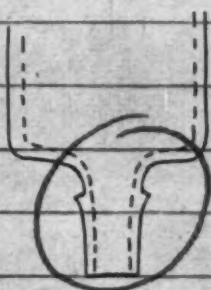
Student nurses and hospital personnel: Regular nutrition and diet therapy courses, which include practical application, are given to student nurses to help them understand their patients' needs. They must be led to recognize the importance of the part played by a well balanced diet in the recovery and maintenance of good health. There must be close co-operation among the doctor, the nurse and the dietitian: this is why discussion groups and lectures are held not only for student nurses but for the graduate nurses and intern doctors as well. These groups foster discussions which help solve the little problems or misunderstandings that may exist. They also inspire the various groups of the professional body of the hospital staff to co-operate and to speak the same language for the greatest benefit to our little patients.

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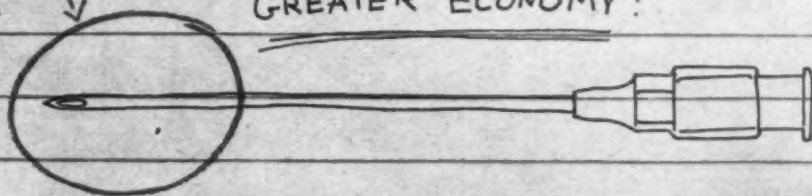
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A Report on

Physiotherapists in Canada

Helen M. Gault
M.C.S.P., M.C.P.A.
Montreal, Que.

Part II

THE initial phases of this report dealt with the number, qualifications and distribution of physiotherapists in Canada, the services they give, the auxiliary personnel who assist them and the cost of maintaining physiotherapy departments. Part II of the report deals with the space requirements for a physiotherapy department, the equipment being used, and the summary and conclusions of the study.

Area Allotted and Amount of Equipment Used.

The questionnaire asked for the total area of the department and space allotted to the gymnasium and large treatment room, and also the number of small treatment cubicles, private rooms, hydrotherapy rooms, and offices included in the total area. Information was also sought on the adequacy of space and rooms provided. Another series of questions was asked to elicit information on the nature and number of pieces of special equipment in use. This report includes only part of the data received in response to these questions.

Size of departments was reported by 97 general hospitals and 45 special hospitals, apparatus by 103 general and 63 special hospitals and centres. Ninety-five of the general hospitals have completed both sets of questions. Of the special hospitals and centres, only armed forces, tuberculosis, geriatric and D.V.A. hospitals and the rehabilitation centres (both with and without in-patients) have been included, making a total of 41 in this second group.

Mrs. Gault is assistant professor at McGill University's School of Physical and Occupational Therapy.

In *table 13* the areas for physiotherapy departments reported by 95 general hospitals are classified by size of hospital into four categories—those considered by the charge therapist to be adequate, fairly adequate, inadequate and totally inadequate. Under each of these headings is shown the total space available per hospital and per therapist. It is realized that the degree of satisfaction with available space is the opinion of the charge therapist. The number of therapists on staff, amount of equipment to be housed, relationship of in-patient to out-patient load, types of conditions treated, and energy and ingenuity of the therapists themselves may all have a bearing on the formation of these opinions. The lack of specification in the criteria for determining adequacy made it difficult to distinguish between the two categories of "fairly adequate" and "inadequate". Where doubt arose, the therapist's statement regarding adequacy of gymnasium or large treatment area was used as a deciding factor.

In *table 14* is shown the average number of pieces of electrotherapy and hydrotherapy equipment, per hospital, in the same groups and hospitals as in *table 13*. Three points stand out when comparing the two tables. Hospitals with unsatisfactory space tend to have as much equipment as those with good space; medium-sized hospitals with departments in the "fairly adequate" category have more space per therapist and less equipment than those in the "adequate" list; and in many hospitals over 500 beds, the less satisfactory the space the more equipment is in use. Explanation of these facts may lie in the nature of the services given or

the arrangement of the physical plant. It may be that much of the work is done in the wards or that a high proportion of electrotherapy treatment is not followed by active physiotherapy. On the other hand, the department may be poorly planned, or provision of unnecessary equipment may have created areas of dead space.

Tables 15 and 16 show space and apparatus in the special hospitals. Rehabilitation centres have been divided to show a comparison between those accepting in- and out-patients and those with out-patients only. It was found that space and equipment in special hospitals is similar to that in general hospitals of the same average space. Rehabilitation centres with in-patients, corresponding to the small hospital group, are not remarkable in the amount of space allotted per therapist, although the over-all departmental area per hospital is much greater. The amount of equipment in special hospitals shows nothing remarkable, but the amount of equipment in rehabilitation centres with out-patients only is very high compared to the total number of qualified therapists.

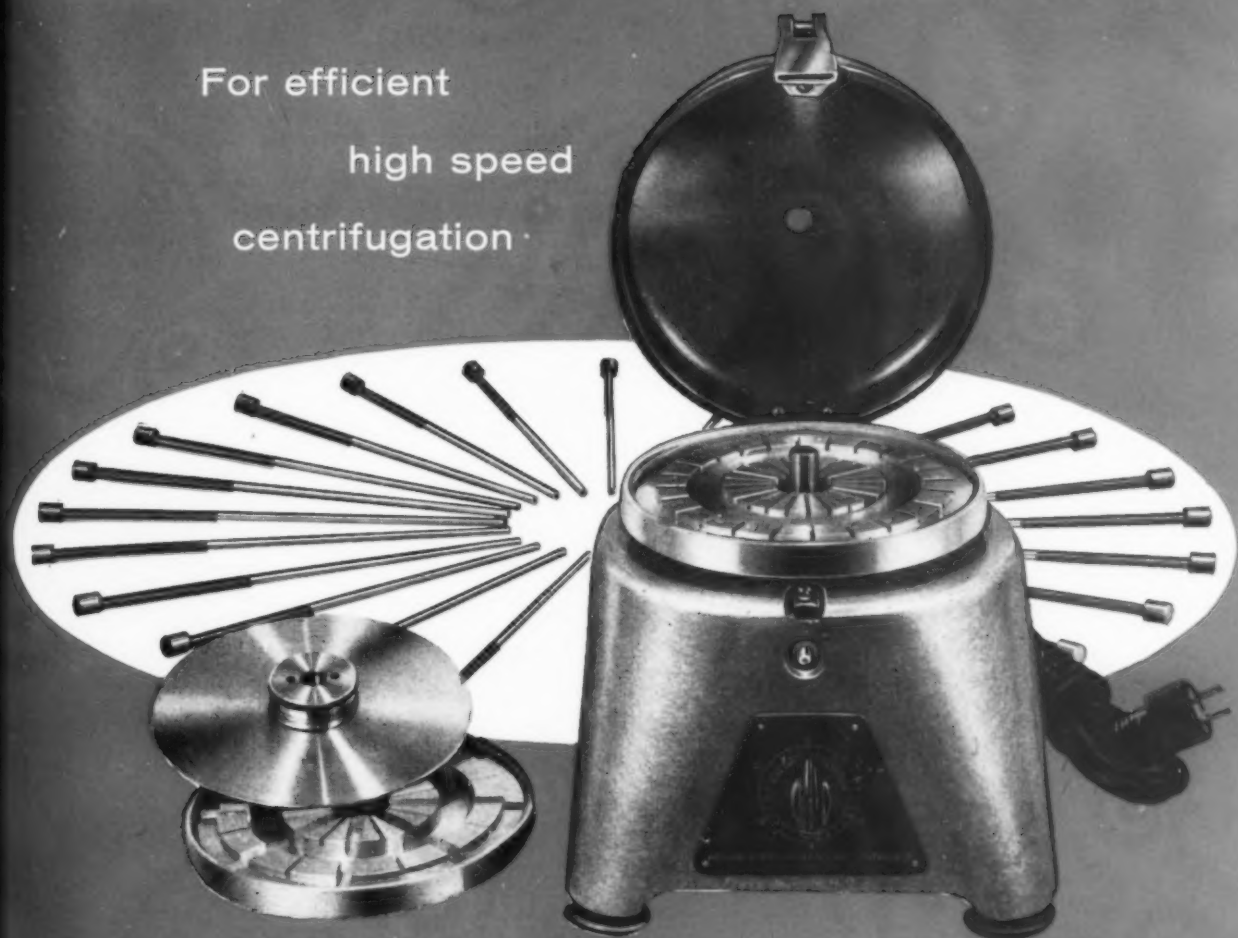
It is recognized that a large gymnasium is important for efficient individual—and group—exercise treatments. In *table 17* the total gymnasium space available in hospitals of varying sizes has been compared with total departmental space in these hospitals. Resulting percentages show that approximately one-third of the total area in general hospitals is used for exercises. The percentage is lower in the larger hospitals because much of their total space is absorbed by small rooms, private rooms and hydrotherapy. Special hospitals apportion half their space to gymnasiums; this supports the hypothesis, in Part 1, that the large volume of treatments per therapist is due to class work and employment of remedial gymnasts.

Of the 41 general hospitals reporting that space is "adequate" or "fairly adequate", only 28 report sufficient space for classes or individual exercise treatments. Many hospitals with sufficient initial space have lost this advantage by having excessive apparatus, and many other hospitals tend to overlook the importance of the gymnasium in an effort to minimize the total area planned for the physiotherapy department. Three-quarter

(Continued on page 78)



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Physiotherapy

(Continued from page 76)

ers of the hospitals with satisfactory gymnasiums are in institutions with long-established physiotherapy departments. In such institutions physiotherapy departments have been rebuilt or replanned because experience has taught that this large free area is essential.

Summary and Conclusion

In an attempt to assess the number and location of physiotherapists, volume of work done, and space and facilities available, throughout Canada, a questionnaire was sent out to all known hospitals and treatment centres. This questionnaire, intended as a basis for a pilot survey of Canadian physiotherapy, covered many more aspects than those analyzed

in the present report. By making the inquiry as broad as possible, we hoped to discover the kind of data most useful to hospitals and to therapists, and the need for its publication. The response proved the existence of considerable interest in such information, but different interpretation of some questions indicated a need for further and more careful inquiries into some aspects.

Five hundred and eighty-eight physiotherapists were reported to be located in 173 hospitals and treatment centres. The majority are in large hospitals of 500 beds and over, and 50 per cent have been trained in Canada. In hospitals with physiotherapy departments, except in one large province, the greater the population the higher

is the ratio of beds to population. The number of trained therapists per 100,000 of the population has not been calculated, but *table 6* gives the total number per province, Canada, as a whole, has approximately 100 beds per therapist in centres where therapy is given. On an average, each therapist sees 33 patients a week and gives approximately 94 treatments. It may be surprising that a therapist in a general hospital averages only about 17 treatments per day, but the range extended from 7.3 to 35.3 treatments per day and no information was sought on the procedures utilized in a treatment.

In special hospitals and centres the number of treatments per day, per therapist, ranged from 5.4 to

(Continued on page 80)

Table 13

Totals and Averages of Space Allotted to Departments of Physiotherapy in 95 General Hospitals

Size of Hospital	Adequacy of Space in Opinion of Charge Therapist	Number Reporting	Number of Therapists	Space in Square Feet		
				Total Space	Average Space Per Hospital	Average Space Per Therapist
1 - 199	Adequate	4	5	7080	1770	1416
	Fairly Adequate	11	18	11336	1030	574
	Inadequate	12	16	9081	757	567
	Totally Inadequate	9	14	3253	361	232
200 - 499	Adequate	8	33	20820	2602	661
	Fairly Adequate	5	12	8908	1781	742
	Inadequate	15	35	13960	913	391
	Totally Inadequate	5	16	3955	751	247
500 and Over	Adequate	6	60	63551	10591	1059
	Fairly Adequate	7	30	22162	3166	738
	Inadequate	8	46	23295	2912	506
	Totally Inadequate	5	29	5498	1100	189

Table 14

Average Figures for Electrotherapy and Hydrotherapy Equipment in 95 General Hospitals

Size of Hospital	Adequacy of Space in Opinion of Charge Therapist	Number Reporting	Average Electrotherapy Equipment per Hospital					Average Hydrotherapy Equipment per Hospital				
			Short-Wave	Micro-Wave	U.V.L. (1)	Infra Red (2)	Ultra Sonar	L.F. (3)	Wax	Whirl Pool	Tank (4)	Pool (5)
1-199	Adequate	4	1.0	.2	1.7	3.0		2.2	.7	1.2	.2	.5
	Fairly Adequate	11	1.8		1.5	2.6	.1	1.7	.7	.6	.3	.2
	Inadequate	12	1.6		.6	1.9	.1	.7	.7	.4	.3	
	Totally Inadequate	9	1.5		1.8	2.2		1.0	.5	.1		
200-499	Adequate	8	3.1		2.2	2.5	.2	2.2	1.2	1.2	.7	.2
	Fairly Adequate	5	1.4	.2	1.4	3.2	.2	1.2	.7	.7	.6	.4
	Inadequate	15	2.2		1.5	4.2	.6	1.5	.9	.6	.3	.1
	Totally Inadequate	5	3.2		1.6	5.8	.6	1.6	1.0	.8		
500 and Over	Adequate	6	7.7	.7	3.5	15.3	.8	4.0	1.8	3.5	1.6	.5
	Fairly Adequate	7	3.4		2.0	13.0	.6	1.9	1.6	1.6	.7	.1
	Inadequate	8	4.6	.4	1.9	5.7	.9	2.2	1.0	2.2	.9	
	Totally Inadequate	5	4.2	.4	2.6	7.0	.4	3.0	.6	1.2	1.0	.2

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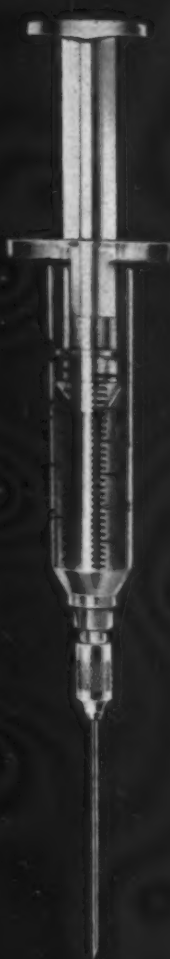
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Table 15
Totals and Averages of Space Allotted to Physiotherapy Departments in Special Hospitals, Average Number of Beds and Amount of Space per Therapist

Description of Hospital or Centre	Number of Hospitals Reporting	Average Number of Beds	Total Number of Therapists	Space in Square Feet		
				Total Space in Dept.	Average Space per Hospital	Average Space per Therapist
Hospitals						
Armed Forces	5	97	10	6796	1359	680
Tuberculosis	3	228	5	2704	901	541
Geriatric	8	308	21	11174	1397	532
D.V.A.	13	697	58	45839	3526	790
Rehabilitation Centres						
In- and Out-Patients	8	101	42	42591	5199	990
Out-Patients only	4	0	44	107862	26465	2406

Physiotherapy

(Continued from page 78)

42.7. The higher numbers are probably due to the employment of remedial gymnasts and to classwork in the gymnasium.

The present services offered by physiotherapy departments in general hospitals, province by province, may be calculated from table 6 by comparing the respective provincial ratios of population to numbers of hospitals, beds and therapists.

The amount of work and number of therapists in the larger hospitals balances approximately the equivalent factors in the small- and medium-sized hospitals combined, but the larger hospitals employ more than half the remedial gymnasts and tend to employ fewer clerical assistants. Calculations of the ratios will show that large hospitals employ five times as many remedial gymnasts as do those of medium size, and also have one and one-half times the number of unqualified assistants, yet the average number of treatments per

therapist in these groups in 110 for the medium hospitals and 112 for the large group. The number of secretarial assistants is low in the large hospitals, considering the number of patients and personnel. One may surmise that the charge therapist, as well as being co-ordinator, has to devote time to book-keeping and must assign an undue proportion of patient-care to auxiliary personnel, for the latter would be classified as secretarial assistance if engaged in clerical duties. This is not a happy conclusion, and it is hoped that further inquiries will clarify the situation.

A similarity will be noted in the general pattern of treatments, space and apparatus. There is cause for concern regarding hospitals in the medium-sized group. Sixty per cent of these report definitely inadequate space — less than half that of the large hospitals yet containing more than half the amount of apparatus. In spite of this, they have a treatment load

of 110 treatments per week, per therapist, against the average of 112 reported by the large hospitals with substantial auxiliary staff.

At the present time, departments reported to have adequate gymnasium space devote one-quarter to one-half of their total space to the gymnasium.

A further survey is required for an analysis of treatments given and proportion of beds in hospitals with physiotherapy departments allocated to such different services as orthopaedics, medical conditions, general surgery and chest surgery, as well as to ascertain the ratio of in-patients to out-patients and duties of the remedial gymnasts and unqualified workers. Such a survey will provide detailed information essential for those who are guiding developments in new and existing hospitals and departments.

With regard to the running cost of a physiotherapy department, it has been mentioned that we have limited knowledge of the basis of

(Continued on page 120)

Table 16
Average Figures for Electrotherapy and Hydrotherapy Equipment in Special Hospitals and Centres

Description of Hospital or Centre	Number Reporting	Average Electrotherapy Equipment per Hospital				Average Hydrotherapy Equipment per Hospital						
		Short-Wave	Micro Wave	U.V.L. (1)	Infra Red (2)	Ultra Sonar	L.F. (3)	Wax	Whirl Pool	Tank (4)	Pool	Bath (5)
Hospitals												
Armed Forces	5	1.8		1.6	6.4		2.6	1.1	1.0	.2	.2	
Tuberculosis	3	.3		1.3	1.0		.3	.6		.3		
Geriatric	8	1.2		.9	4.2	.4	1.1	.9	.8	.9	.1	
D.V.A.	13	3.8	.1	3.4	13.0	.4	3.1	1.4	3.2	.8	.6	.2
Rehabilitation Centres												
In- and Out-patients	8	1.5	.1	1.0	8.0	.5	3.0	1.7	1.2	.6	.2	.1
Out-patients only	4	11.0	1.0	11.0	20.5	.7	5.2	3.2	4.5	1.0	.7	

Key:

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Medico-Legal Problems

Part III

Consent

The importance of obtaining written consent, after clearly explaining what is proposed to be done and the reason for the procedure, cannot be over emphasized. The consent is not of much value unless, when it is obtained, the situation is carefully explained to the patient in such non-technical terms that the average layman would understand the explanation. The patient must be clearly advised of the nature of the treatment and the probable risks involved.

In an American case (*Corn v. French*, 5 C.C.H. Neg. Cases 2d 356—Nev.) quoted in the January, 1957, issue of *Hospital Management*, it was held that failure to explain an operative consent (and to make a biopsy) is malpractice. Remember that the right of a patient when consulting a doctor is to have an examination, a diagnosis, advice and consultation. Then it is for the patient, not for the doctor, to decide what, if any, treatment or operation shall be performed.

An unauthorized extension of surgery beyond the scope permitted by the patient's consent can only be legally justified in an emergency when strict adherence to the terms of the consent would endanger the life or health of the patient. On occasions of emergency, however, great latitude may be permitted a surgeon in the exercise of his judgment and professional skill. Whether or not the situation was an emergency is a question of fact to be decided in each case.

Parmley v. Parmley & Yule (1945) 4 D.L.R. 81, (S.C.C.), held

Frederick Evis, B.A., M.D., D.P.H., is a barrister and solicitor, and medico-legal consultant to the Ontario Hospital Services Commission. From a paper presented at the O.H.A. Convention, October, 1957.

Frederick Evis, M.D.,
Toronto, Ont.

that no amount of professional skill can justify the substitution of the will of the surgeon for that of his patient. In *Winn v. Alexander* (1940) 3 D.L.R. 788, the Ontario Supreme Court held that an unauthorized (i.e., not consented to) operation amounts to an actionable assault.

While the consent of a husband is not strictly necessary for an operation performed on his wife, even if it involves rendering her sterile, it is, nevertheless, wise for practical reasons to secure such consent, if possible. It will help to prevent disputes about hospital and medical accounts.

Also, Dr. K. G. Gray, Q.C., in his text, *Law and the Practice of Medicine*, quotes an unreported decision of Kelly, J. of the Supreme Court of Ontario in which two successful doctor defendants were deprived of their costs in the action only because they had failed to obtain written consent from the husband for a sterilization on his wife. With respect, in my opinion, this is an inadequate reason for withholding costs, but it serves to illustrate the prudence of obtaining operative consent from the spouse whenever possible.

In view of the installation of television equipment for teaching purposes in some hospitals in Ontario, and of the increasing popularity of the use of photographs, projected slides, and moving pictures as teaching material, it is opportune to mention the need for the consent of the patient to such procedures. When it is proposed to televise, take pictures or sound recordings of a patient during the course of an operation or other treatment, it is advisable to obtain the patient's written consent to do so. Moreover, since the patient has certain legal rights as to the use to which the photo-

graphs, et cetera, will be put, William C. J. Meredith, Q.C., in his text, *Malpractice Liability of Doctors and Hospitals*, wisely suggests that the authorization should include a general waiver that the material is "to be used for scientific purposes only, including publication in scientific and professional publications and exhibitions to scientific and medical authorities", plus a waiver of all claims with regard to the photographs, et cetera.

Post Mortem Examinations

Official autopsies ordered by a coroner or other authority under power delegated by means of a statute should cause hospital authorities no great amount of worry. However, unofficial post mortem examinations require consent and can cause great difficulty. The following general principles apply to such cases:

(a) A person cannot by will, contract, or other instrument dispose of his body.

(b) The right to possess the body for burial purposes rests in the surviving spouse.

(c) Divorce or legal separation terminates the legal relationship between the spouse and the right of one to dispose of the body of the other.

(d) If there is a will naming an executor, then it is the executor who has the paramount right to disposal of the body.

(e) In the absence of an executor and a spouse, the next-of-kin have authority over the disposal of the body. All children have an equal voice, if of age and not illegitimate.

(f) Next-of-kin means a person or persons in the nearest degree of relationship by blood. Therefore the term does not include spouse, who stands in a special relationship ahead of next-of-kin, nor does it include any "in-law".

(g) There are circumstances in which the spouse and children may forfeit the right of burial, as where they have abandoned the deceased, or failed to give needed support, or have indicated a lack of affection by indifferent or hostile conduct. In such circumstances a more distant relative or even a friend who has cared for and frequently visited the deceased may have a superior right over one nearer of kin.

As a practical working rule, most hospitals will be reasonably

(Continued on page 104)

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MIND
over
MATTER

(Conclusion)

WHEN people are faced with stress, when they become tense, nervous or perturbed, they try to seek relief from the stress consciously or unconsciously. They may escape into psychosomatic illness or they may have a nervous breakdown.

The misconceptions of a nervous breakdown are as numerous as its symptoms. One mistaken idea is that the patient is sick because he wants to be. That is wrong. He is overwhelmed by certain forces which he cannot meet. The second misconception is that the patient can get well by his own free will. Sometimes we drive these people to suicide by saying "Come on, pull yourself together. All you need is guts." These people cannot cure themselves. It is a misconception also that all nervous breakdowns are due to sexual frustration. There are many other frustrations.

Another mistaken idea is that the general practitioner cannot treat a nervous breakdown. Very

David Lander, M.D.,
Black Diamond, Alta.

often if he will take the trouble, he can treat the patient as well as a psychiatrist because he knows the patient's background. He knows the skeletons in his closet and he speaks the patient's language. If general practitioners would interest themselves a little more in psychological medicine, the clamour for more psychiatrists would not be so urgent.

Patients try various escapes—psychosomatic illness or neurosis, or alcohol or drugs. Some people try to escape into travel. Many a neurotic thinks he can cure all his ills by a dose of applied geography. Our trains, our boats, our aeroplanes are filled by people who are running away from something. Other people try to run away from their strains and stresses by motor activity. When I get mad I go for a walk, too, but if motor activity becomes a compulsion, it is no longer normal. You find perpetual

women shoppers, women who are always polishing, gregarious individuals who are never at ease unless they are at a party. These are all escapes.

We must realize that none of these instances of stress diseases is the result of an incident. The unfavourable incident acts as a match which ignites a firecracker. Whether or not the firecracker will go off depends on the quality of the gunpowder — which is determined by heredity, early upbringing and the ability to face frustration.

To treat a case like this you can try to douse the match. If you do something about the environment, the person will not explode, no matter how explosive he is. Or you can try to tone down the explosive quality of the gunpowder, so that it will not ignite in spite of the match. Either way you are using psychotherapy. Some doctors shrink away from psychotherapy as if it were something unholy. Actually, except for the pathologist, all doctors practise it. Psychotherapy consists in listening, counselling, reassuring and guiding the person. Sometimes it means going out and finding a job for him. It consists in showing the patient why he is ill, why he wants to be ill, or why he may have to be ill.

Illness very often serves a purpose. When this is true, the patient will not give up his illness, as it may be saving him from having to face an unpleasant situation. A young medical missionary who went to India as an eye specialist, came upon a blind man begging for pennies. Immediately looking at his eyes, he saw that the man had cataracts. Thinking that here was his chance to do something good, he said, "Man, I can make you see."

"Don't bother me," the beggar answered.

"It won't cost you a thing."

"Don't bother me," the beggar answered.

The doctor couldn't understand it. He went back to the hospital and asked his chief for an explanation. "Well," the chief said, "this one is easy. When that man had his eyesight he was poor; he was starving. When he developed the cataracts it was a terrible tragedy but it made him go out and beg. He does so well with his begging that he has a home for his family and he can feed them. He doesn't want to see anymore."

(Continued on page 86)



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Mind over Matter

(Continued from page 84)

We see many somewhat similar situations in life. In order to help these people who are suffering from psychosomatic illness you must develop a particular kind of relationship with the patient. With some people you establish a father-child relationship (transference). Many of them never really had a father. The doctor's position changes with the age of the patient, however. With very old people he must be the devoted child who listens to the patient. He doesn't tell them that they have to do this and that, he advises them more subtly.

The first thing to do, if possible, is to relieve the stress situation which is causing the illness—separate the two families that are living together, remove the mother-in-law. The next battle is with the patient's rigid personality. You must teach him to develop a more nonchalant attitude towards life. He must learn to lower his sights, to allow for human weakness, frailty, and shortsightedness. He has to be taught that any virtue pushed too far is a vice which destroys human happiness. Since they cannot become gods, men must strive to become better men.

A lot of these people can be helped in hospital. There they are away from their unpleasant environment. While they are in hospital the doctor can manipulate their environment to make it more livable when they return to it. It also gives him the chance to talk to these people. To help them I feel he should spend sometimes half an hour each day teaching them how to meet their life situations. When the nurse acts as his eyes and ears, she can be of great help to the doctor. She sees the patient under all circumstances, sees who visits him and how he reacts to these visitors. Unfortunately it seems that nurses are often too busy with their charts to spend that much time in the wards. Besides few nurses like the nervous patient. Sometimes the reason for this dislike is that they see their own weaknesses in the patient. A good nurse, as much as a good doctor, needs a lot of basic humility as well as a third ear.

Because of the great complexity of human sufferings, nurses and doctors must learn to deal with human happiness and fear as well as with pain. The relation between doctor and patient

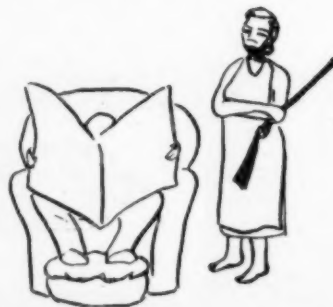


Environmental Surgery.

depends as much on understanding, forbearance and unselfishness as that between father and child. We must realize that patients come to us not only with damaged bodies, but with bruised minds, lacerated consciences and broken hearts. It seems that the treatment of these emotional people falls into three classes—the millionaire goes to the psychoanalyst, the rich man to the psychiatrist, and the poor man to the general practitioner and has to be satisfied with phenobarb. The general practitioner has to treat the mind of the patient too.

Where do these tensions arise from? They have many sources, different in the child and in the adult. In adulthood most anxieties are due to maladjustment in the marital relationship. Marital conflict due to mismating very often results in psychosomatic illness. After you come to know a patient and you ask her why she married, she will frown and ask herself, "Now, why did I get married?" Sometimes the real reason is family coercion, fear of financial insecurity, fear of remaining single, or pressure from matchmaking friends. None of these reasons is strong enough to produce a stable marriage.

Temperamental differences can also result in marital conflict. A marriage between extreme opposites in temperament requires from



Contemplating acute treatment.

each a high regard for the other's dignity. You can't change the pessimist into an optimist, and you can't change the spendthrift into a pennypincher without creating tension which expresses itself in a psychosomatic illness. Mating between an alert person and one who is dull and sluggish can also result in difficulty; intellectual compatability is one of the most important factors in a happy marriage. Neither physical attraction nor material comforts can compensate for lack of shared interests.

Many a psychosomatic illness is the result of a poor marital decision.

Economic factors are also very important. When people are working hard together they usually get along together. Added wealth seems to get them into difficulties. Out in Turner Valley, for example, we have many women whose husbands started at \$4.00 a day, but who are now earning \$40.00 a day. As an executive the husband is away from home, he goes to parties, and the wife is left out and feels neglected. Very often emotional illness is an escape from this feeling of neglect. An ancient philosopher put it well when he said, "Woman's torment is not man's tyranny, but his indifference." These women are tormented by uneasiness when their men become uncommunicative. The husbands say you can't talk to women, you can't discuss business or politics with them. Because they know nothing about business and politics they are relegated to the kitchen, and because they are relegated to the kitchen they are able to learn nothing about business and politics. Gradually the husband and wife cease to share their lives with each other.

Some time ago we had to commit a farmer's wife to a mental hospital because she had taken after her husband with a meat cleaver. "John," I said to the husband, "have you any idea what brought her to this?"

He looked at me very seriously and answered, "I really don't know what got into her. She hasn't been out of her kitchen for 30 years."

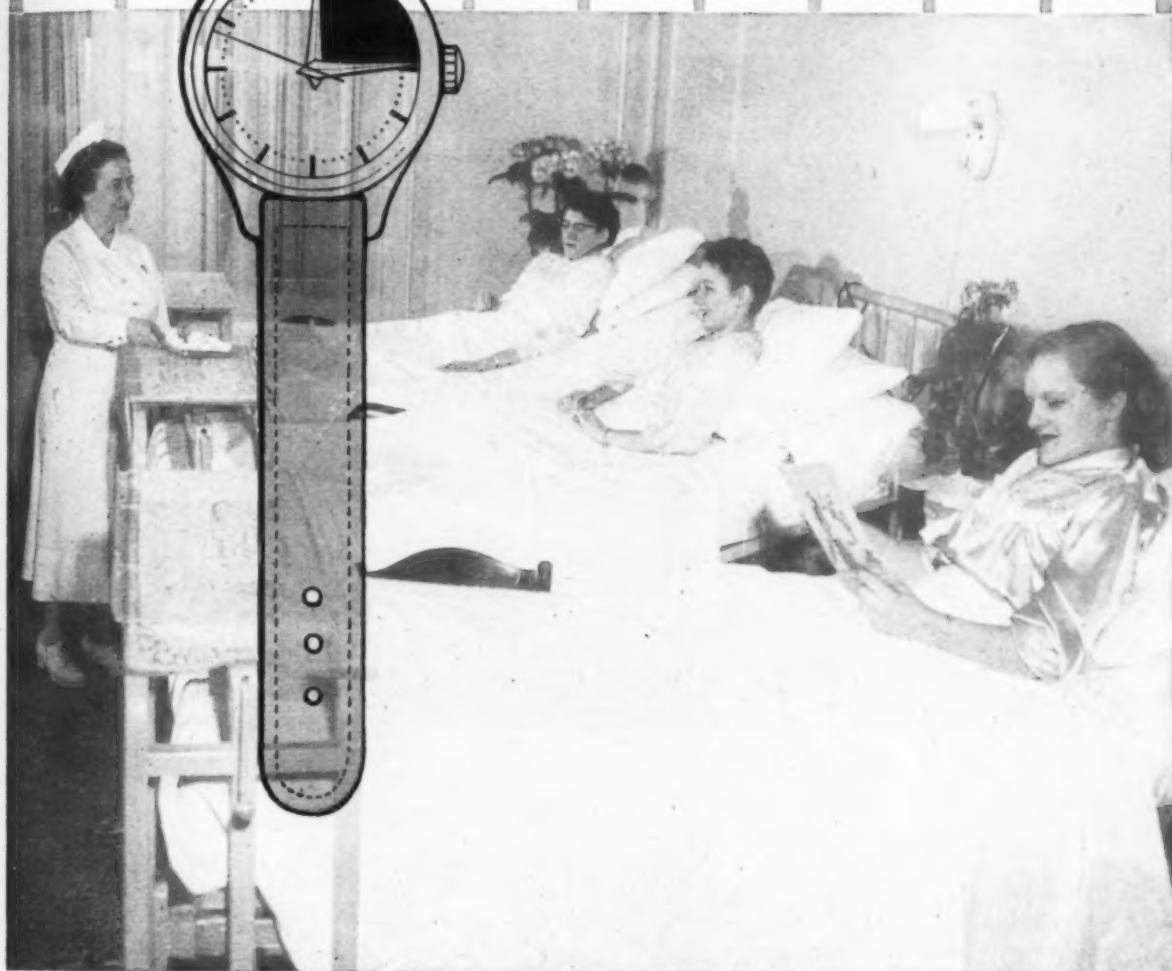
Giving a woman a luxurious home, good clothing and jewellery is not enough. An intelligent woman doesn't want to sleep with a man, she wants to live with him. Byron said, "Love in a man's life is a thing apart; it is woman's whole existence."

When someone asked a famous

(Concluded on page 118)

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1. E. G. Gooby and D. R. Turnbull: *New Technic of Administering Medications*, *THE CANADIAN NURSE*, (August) 1957.

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◀ Provincial Notes ▶

Newfoundland

The Western Memorial Hospital in Cornerbrook has had 100 per cent occupancy for over a year. A new wing is planned to provide about 120 additional beds.

Prince Edward Island

Salaries have been raised and most groups of non-professional employees have been reclassified in provincial hospitals here. Employees at the Provincial Sanatorium and the Rehabilitation Centre in Charlottetown, will also receive the increase. It has been several years since the previous reclassification, and the new scale lists minimum and maximum salaries for each position with the annual increase to be received by each individual on the recommendation of the director concerned.

Nova Scotia

The Red Cross outpost hospital in Arichat, founded 11 years ago to serve Isle Madame was officially turned over to the community by Red Cross authorities recently. In a colourful program, the Red Cross Society was praised for its efforts in keeping the hospital operating for so many years, looking forward to the day when the community itself could look after the hospital's direction. It is hoped that within a few years the hospital, now called St. Anne's, will be replaced by a modern hospital.

New Brunswick

A new 60-bed wing for Hôtel-Dieu de St-Joseph, Campbellton, has been officially opened. This opening marked the 70th anniversary of the founding of the hospital.

A four-storey addition, to cost an estimated \$400,000, is being planned for the Victoria Public Hospital, Fredericton. Architects

are Govan, Ferguson, Lindsay, Kaminker, Langley and Keenleyside, Toronto.

Quebec

A new Guerette Private Hospital, costing \$40,000, has been built in Jacques Cartier to replace the present hospital in Longueuil. The older building is to be converted into a convalescent home.

Reconstruction of the Hôtel Dieu in Nicolet, partly destroyed by a fire in 1955, is now well under way. A building of three floors will be erected, and will be joined to that part of the hospital which was undamaged. It is hoped that the new hospital building will be opened in the autumn of 1959.

Ontario

The contract has been awarded for the new 250-bed Welland County General Hospital, Welland. Begun in July, construction is expected to take two years.

Approval has been granted for an addition to Victoria Hospital, Renfrew. Planned are additions and alterations that will increase the hospital's bed capacity to 100. Total cost is expected to be \$968,000.

Architects Critchley and Delean of North Bay have prepared plans for Kirkland and District Hospital's new wing, an addition which will make the hospital, located in Kirkland Lake, the largest in north-eastern Ontario. The new wing will provide space for an additional 28 active treatment beds for adults, and 32 children's beds, as well as a physiotherapy department and administrative offices. This will raise the total number of beds to 163 (including the 20 for chronically ill patients). The over-all project is to cost approximately \$600,000.

Plans have been made for alterations to the Toronto Hospital for Treatment of Tuberculosis, Weston. Architect is Arthur Heeney, Toronto.

A \$5,500,000 project for Port

Arthur—the construction of a medical-surgical building at the Ontario Hospital—has been announced. The four-storey building will be situated between the pavilions and the administration building and will resemble a "W" in shape.

Canada's first tri-service hospital is nearing completion at Barriefield. The modern, three-storey building is to replace the present one-storey Kingston Military Hospital. The new hospital will have 125 beds, and, although administered by the army, it will be staffed with personnel from army, air force and navy.

It has been announced that the Ontario Cancer Institute, beside Wellesley Hospital (a unit of Toronto General) in Toronto, is to be known as Princess Margaret Hospital.

Under consideration for five years, the expansion plans of Brockville General Hospital have been enlarged, and the estimated cost has been increased to \$2,167,500. It was originally decided to construct a four-storey west wing, and a three-storey east wing, and to double the size of the nurses' residence. Now the west wing is to consist of six storeys, and the new east wing will have a basement and two storeys above street level. There will also be alterations to the old section of the hospital—39 beds will be taken out of service, sun-parlours will be demolished, the building will be fire-proofed. The increased expansion will give the hospital 179 new beds.

The greater Niagara General Hospital in Niagara Falls was formally dedicated and officially opened on July 16. The new ranch-style building has a capacity of 262 beds.

Manitoba

The beautiful new eight-storey replacement wing of Deer Lodge Hospital, Winnipeg, is now complete; maximum use is being made of its modern facilities. The new building stands on the site once occupied by rambling, two-storey wooden pavilions erected in 1940 to meet the heavy flow of European casualties. Now the hospital boasts a modern design and gleaming, up-to-date facilities. Besides this, small dining rooms have been provided for patients on each floor—

(Concluded on page 124)

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C.S.R.T. Convention

Held in Winnipeg

IN JUNE of this year, Winnipeg was host, for the third time, to the national convention of the Canadian Society of Radiological Technicians. The 16th C.S.R.T. convention, held at the Fort Garry Hotel, presented four closely-packed days of education, business, and social relaxation. The local society, under the chairmanship of Des Butler, is to be congratulated upon their energetic planning of the affair, and also upon the efficient manner in which it was operated. The registration of about 150 was not the highest ever recorded, but it is noteworthy that these 150 members, including delegates from nine of the ten Canadian provinces, enthusiastically attended all the functions and contributed greatly to their success.

Many travelled by plane and arrived the preceding night, ready for the official opening ceremonies on Tuesday morning. Under the chairmanship of Hugh Gibson, Manitoba division president, greetings were tendered by Dr. M. R. Elliott, deputy minister of health, by the acting-mayor of Winnipeg, Alderman A. E. Bennett, by Dr. M. K. Kieran, president of the Manitoba Association of Radiologists, and by Mary Rudder, past president, American Society of X-Ray Technicians and official delegate of that society.

The first business session followed; here the various committee reports were presented. After this, there was a luncheon, sponsored by the Manitoba Medical Association. The post-luncheon activities proceeded with William Doern, C.S.R.T. president, as chairman, and included a talk by Dr. J. L. Downey, who represented the M.M.A. A feature of the program was the presentation of a handsome presidential chain of office, given to the society by Dr. E. A. Petrie, Saint John, N.B. (unfortunately not able to be present). The first recipient was William Doern. The

The author is chief technician, department of radiology, Hospital for Sick Children and editor of "The Focal Spot."

L. J. Cartwright, R.T.,
Toronto, Ont.

links of the chain are engraved with the names of the 16 past presidents—George F. Reason, 1943; Claude J. Bodle, 1944; Mary F. Cameron, 1945; Thomas B. Hurst, 1946; Persse E. Hunt, 1947, 1949 and 1953; Henry C. J. Simkins, 1948; Herbert M. Welch, 1950; William Doern, 1951 and 1958; William Stirling, 1952; John Collins, 1954; Albert R. Cheffins, 1955; S. Mel Smith, 1956; and David C. Sage, 1957. Two of these officers, George Reason and Herbert Welch are now deceased. Presentation of individual past president pins was then made to everyone mentioned.

Later, the first technical session was held when five excellent papers were presented. D. Fisk of Montreal, Que., spoke on "The History and Heritage of Radiography". Sister M. deLellis of Saint John, N.B., dealt with "The Respiration Factor in Radiography". A subject of great importance in Saskatchewan's wide-open spaces was chosen by H. Heaton of Shaunavon, Sask., as he presented—"An Answer to the Radiological Problem of the Small Hospital". An instructive talk on "Obstruction Emphysema due to Non-opaque Foreign Bodies" which pointed out the importance of inspiration and expiration films, was given by Dr. G. F. Boulton of Winnipeg General Hospital. The therapeutic aspect was ably handled by M. Bolster of the Ontario Cancer Foundation, Kingston, Ont. Her subject was "Localization—The Diagnostic Radiographer's Role in Radiotherapy".

In the evening, a tour of Winnipeg revealed a well-wooded prairie city. The visitors sped along beautifully boulevarded residential roads, eventually reaching the wide expanses of Assiniboine Park on the banks of the Assiniboine River. The luxuriant tropical growth and the blaze of flowers in the conservatories were also seen—and appreciated.

The following morning, the three refresher courses by Arthur Fuchs, Ray Fujimoto and Louis A. Staniszewski continued, with a total registration of about 85. A business session followed later in the morning, and in the afternoon another technical session took place. Outstanding among the talks given were those of Frank Dreisinger, Picker X-Ray Corporation, on "Minimal Dosage Radiography", and Dr. A. L. Meikle, St. Boniface Hospital, on the "Radiotherapeutic Armamentarium". In the evening, the conventioners relaxed, and were entertained at a lavish smorgasbord at VasaLund Park. A pleasant period of square dancing followed.

On Thursday, St. Boniface Hospital, across the Red River, was host at a luncheon in the new wing, after which visitors enjoyed a tour of the new and well-equipped x-ray department. The afternoon was taken up with technical papers, among which were the award-winning "Cobalt 60 Therapy versus Conventional X-Ray" by Edna Dobson, R.T., Ontario Cancer Foundation, London, Ont., and "Choice of Technical Factors in Radiography" by J. Morgan, General Electric X-Ray Corporation. In the early evening, supper was served at the Winnipeg General Hospital; then there was a visit to this hospital's interesting new x-ray wing—differing from the usual long corridor layout in being fundamentally a square plan.

Friday afternoon was devoted to still another technical session, which included the Welch Memorial Lecture "Today and Tomorrow", by L. J. Cartwright, R.T., Toronto, Ont. The afternoon concluded with an open forum panel discussion which drew lively audience participation.

A cocktail party, given by the Manitoba radiologists began the evening festivities. Then came the annual banquet. The guest speaker was A. J. Kember, public relations supervisor of the Manitoba Telephone System, and a most interesting and humorous narrator of unusual incidents in the telephone business. Presentations included the Mallett Award Trophy for outstanding service to the C.S.R.T. to W. Stirling, Vancouver, B.C.; a pair of cuff-links and ring to Arthur Fuchs for the valuable educational services he

(Concluded on page 124)

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Historique de Ste-Justine

(Suite de la page 36)

gisature fut obtenue. Il fallait à l'Hôpital beaucoup de conviction et de travail pour faire son chemin parmi tant "d'ainés" qui avaient déjà des titres authentiques dans le domaine hospitalier.

C'est également en cette année de 1918 qu'un premier laboratoire était organisé.

En 1921, se faisaient entendre déjà depuis plusieurs années des lamentations et des regrets à propos de l'exiguïté du local; il fallait

donc songer à agrandir de nouveau. Une souscription publique fut ouverte et, le 4 août 1921, des contrats furent signés avec M. Joseph Sawyer, architecte, et M. Damien Boileau, entrepreneur. Je cite ces noms car, fait remarquable, en 1951, ce sont encore les mêmes qui signeront les contrats de la dernière entreprise de notre hôpital, chemin Sainte-Catherine. La continuité des amis et des artisans de l'Hôpital a toujours été remarquable à Sainte-Justine et a, sans aucun doute, aidé à son succès.

En 1922, Mlle Euphrosine Roland, une des fondatrices de Sainte-Justine et celle qui a répondu au premier appel fait en faveur d'un hôpital pour enfants, fut en même temps l'instigatrice de l'organisation du Service social qu'elle avait tant préconisé depuis le début de l'Hôpital et dont les malades de Sainte-Justine bénéficient encore. Les enfants qui ne peuvent être hospitalisés faute de place, sont visités par nos visiteuses sociales et tous nos enfants sont également suivis après leur sortie.

L'année 1924 vit s'installer chez nous un service d'obstétrique, complément normal de notre oeuvre d'enfants et offrant un grand avantage pour faciliter la formation de nos infirmières.

Le 31 août 1925, première pelletée de terre enlevée pour un autre agrandissement de l'Hôpital par la construction d'une aile au sud.

Le Dr Raoul Masson était nommé titulaire de la chaire de pédiatrie et le Dr Gaston Lapiere, agrégé en pédiatrie, tandis que le Dr. Ferron était nommé en chirurgie infantile. Un bel avenir s'accroissait tous les jours d'avantage.

Une autre de nos fondatrices, Mme Théodule Bruneau (Lucie Lamoureux) fondait, à Sainte-Justine, une école pour les enfants infirmes. Vraiment l'on doit reconnaître à Mme Bruneau le grand mérite d'avoir été une pionnière dans les organisations d'oeuvres en faveur des infirmes. Elle provoque en leur faveur cette sympathie qui est devenue si effective aujourd'hui.

Lors du vingtième anniversaire de fondation de Sainte-Justine, avait lieu l'inauguration du nouvel agrandissement et Son Excellence Mgr Casuelo, délégué apostolique, nous honorait de sa présence; il avait été spécialement invité par Mgr Georges Gauthier, notre archevêque, qui a toujours été un grand animateur de nos énergies et de notre foi.

En 1931, il était encore question d'agrandissement, sur la rue de Saint-Vallier cette fois, pour loger notre Ecole d'infirmières, les laboratoires, la buanderie et les ateliers. Encore une construction urgente pour laquelle l'Hôpital reçut une subvention de \$30,000. Malgré ce don de la ville de Montréal, force majeure, il fallut hypothéquer le nouvel immeuble. L'audace, les risques, tout cela devait être à la hauteur de notre but: sauver nos

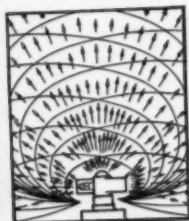
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SEPTEMBER, 1958

Historique de Ste-Justine
(Suite de la page 96)

enfants malades. Les progrès, en retour, dédommageaient des labeurs et des migraines financières. L'Université de Montréal reconnaissait à Sainte-Justine l'enseignement clinique des maladies contagieuses et lui attachait, comme professeur de service, le Dr. J.-A. Leduc, titulaire dans ce domaine.

Une nouvelle chaufferie devint nécessaire. Elle fut construite sur la rue de Saint-Vallier et les tra-

voux et les plans en furent confiés à M. de Gaspé Beaubien, ingénieur conseil. Une subvention de \$150,000 nous fut octroyée par le gouvernement de la province de Québec.

L'année 1937 vit l'inauguration d'un service de bronchoscopie, service à peu près unique à cette époque.

Notre Ecole d'infirmières s'est toujours tenue à date et, en 1938, Soeur Valérie de la Sagesse, qui en était la directrice, fut appelée à la présidence de l'Association des

Infirmières de la province de Québec.

L'activité était grande à Sainte-Justine et le travail continuait d'être le plus grand capital employé à la réussite de l'oeuvre.

La Commission des Ecoles Catholiques de Montréal se rendant compte de notre obligation morale vis-à-vis les enfants qui, malades, risquent de perdre leur année d'étude, nous accordait, depuis 1940, des professeurs pour l'enseignement pédagogique, de même qu'un professeur en travaux sur bois. J'ai bon souvenir d'un jeune garçon qui, condamné pour la vie à se servir d'une chaise roulante, gagne depuis plusieurs années agréablement sa vie grâce à la formation acquise pendant son séjour à l'Hôpital.

En 1942, le Dr Edmond Dubé recevait la charge de titulaire de la chaire de chirurgie infantile et orthopédique de l'Université de Montréal. Devant l'accroissement de l'ouvrage et de la responsabilité de cet hôpital qui ne cessait de grandir et de se perfectionner, on dut porter à onze le nombre de ses administratrices.

En 1945, Mgr Olivier Maurault, recteur de l'Université de Montréal, nous faisait part de son grand désir de voir Sainte-Justine auprès de l'Université, désir exprimé à l'assemblée générale de la Corporation.

Voici que la même année se présentait le grand avantage d'acquérir le terrain avoisinant celui des Révérends Pères Jésuites, chemin Ste-Catherine, sur lequel furent jetées les bases de notre nouvelle construction. Ici, je dois rendre hommage au Père d'Orsonnens, s.j., qui nous facilita si généreusement cette transaction.

En 1946, année de la grande épidémie de polio, l'hôpital réussit à soigner 516 patients en plus de sa capacité normale d'hospitalisation. Toujours le rôle de Sainte-Justine a été de répondre spontanément à l'appel des enfants malades.

Un plan de fonds de pension fut établi cette même année pour tout le personnel de l'hôpital.

Encore en cette année d'heureux événements nous survinrent. Notre directeur médical fut réélu doyen de la faculté de médecine de l'Université de Montréal, et un peu plus tard reçu le titre de Fellow de l'American College of Surgeons.

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(Suite à la page 100)



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Historique de Ste-Justine
(Suite de la page 98)

perspectives d'activités nouvelles, il a fallu encore que la Corporation obtienne une augmentation de pouvoir de possession de valeur d'immeubles et de le porter de trois millions à dix millions. Lentement, mais prudemment, Sainte-Justine s'avance vers un grand épanouissement.

Un autre consolant et encourageant témoignage rendu à notre organisation administrative fut la

nomination de membre honoraire de l'American Hospital Association, accordée à la présidente de Sainte-Justine en reconnaissance de l'efficacité du travail des bénévoles dans les hôpitaux. Cet hommage rendu à un bénévolat sincère et effectif répondait si bien au désir et à la mentalité des fondatrices de l'hôpital.

En 1949 une première maison payée par un des plus généreux donateurs de l'hôpital fut élevée à titre temporaire sur nos terrains,

chemin Ste-Catherine, pour démontrer que nous avions pris position sur notre propriété et une clinique externe pour la psychiatrie y fut installée, puis notre service d'orthophonie fut ajouté.

En 1950, à ce tournant du demi-siècle, l'hôpital entraînait dans une période définitive de construction et de campagne de construction. Plans et projets furent élaborés avec toute l'envergure de la destinée de notre oeuvre pour les enfants.

Le 3 juin 1951, jour inoubliable, fut bénite la pierre angulaire de notre nouvel hôpital par Son Eminence le cardinal P. E. Léger qui parla si éloquemment de l'importance d'un hôpital pour enfants. L'Honorable Maurice Duplessis scella l'ouverture qui avait été faite pour recevoir les précieux documents d'usage et cela en présence de Son Honneur le Maire de Montréal, M. Camilien Houde, du Ministre de la Santé du gouvernement provincial l'Honorable Albiny Paquet, de celui du gouvernement fédéral, l'Honorable Paul Martin et d'une foule d'éminents citoyens et de très nombreux amis.

C'est grâce au bel octroi de \$3,000,000 dont nous fit alors part l'Honorable Premier Ministre que nous avons pu mettre en marche nos projets d'agrandissement et procéder au Nouveau Sainte-Justine. Le Premier Ministre adressa les paroles les plus réconfortantes pour le travail accompli et les plus encourageantes pour l'avenir.

Nous avons donc pu poursuivre notre entreprise au prix toutefois de bien des labeurs et des soucis. Un comité de construction composé des architectes, de l'ingénieur conseil, de notre conseiller juridique, de deux représentants du conseil médical, deux représentantes des religieuses et le conseil d'administration de l'hôpital fut formé auquel fut adjoint le contracteur général et le directeur des services. Je tiens à souligner le fait remarquable que ce comité composé de vingt-deux membres s'est réuni toutes les semaines de 1952 à 1958. Quel exemple de franche collaboration.

Nous avons aussi eu recours à des experts en construction d'hôpitaux tel que les consultants Neergaard, Craig, Agnew et Westerman de New York et Agnew & Peckham de Toronto. Le plan de notre hôpital réalisé par nos archi-

(Suite à la page 102)



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Historique de Ste-Justine
(Suite de la page 100)

tectes Jos. Sawyer et Henri S. Labelle ne peut que vous parler très fortement en leur faveur. Grâce à l'expérience et aux études spéciales de Soeur Noémi de Montfort et, en plus, d'une connaissance vécue par cette religieuse, la réalisation du fonctionnement interne de l'hôpital nous a été rendu de beaucoup plus facile. C'est à cette constante et franche collaboration

que nous devons beaucoup pour l'épanouissement continu de Sainte-Justine.

L'administration de l'hôpital est assurée par un conseil d'administration, par un conseil médical chargé de la direction médicale, par une régie interne confiée à une congrégation religieuse: les Filles de la Sagesse. Une école d'infirmières est attachée à l'hôpital.

Dans l'historique de l'évolution de notre hôpital, je dois à la mé-

moire du Dr Malcolm MacEachern une mention pour les sages conseils qu'il nous a donnés et l'intérêt qu'il a manifesté à notre hôpital, ce qui a toujours été un fort stimulant pour nous.

En 1955 les bureaux administratifs étaient temporairement transportés dans l'école des infirmières, ce local étant le premier terminé du grand projet de notre nouvelle construction. Le 5 juillet le Conseil d'administration tenait sa première assemblée dans son local définitif et officiel. Le 11 septembre une première messe était célébrée par Son Excellence Mgr Laurent Morin, dans un petit oratoire au 4e étage des infirmières.

Enfin le 20 octobre 1957 eut lieu le grand d'm'nagement si impatientement attendu qui s'est effectué dans le plus grand ordre, avec un sourire sur toutes les figures.

C'était une apothéose après cinquante ans d'espoir, de labeur et d'endurance et enfin de réussite.

Le 9 novembre Son Eminence bénissait notre nouvel immeuble et recevait, en traversant nos corridors, les plus touchants témoignages de reconnaissance et de joie profonde.

Et l'après-midi avait lieu l'inauguration du nouvel hôpital. Le Premier Ministre, l'Honorable Maurice Duplessis, a ratifié ses paroles d'encouragement en donnant de très généreux octrois. Déjà, la Législature provinciale avait adopté une loi exemptant des formalités ordinaires les dons et legs faits à l'Hôpital Sainte-Justine.

Les autorités fédérales et municipales de tous les coins de la province ont accordé leur encouragement et sous l'habile direction de monsieur G. G. Ryan, du Brigadier J.-Guy Gauvreau et de monsieur Charles de Lotbinière Harwood, le public a souscrit généreusement au cours des trois campagnes en 1951, 1954 et 1957.

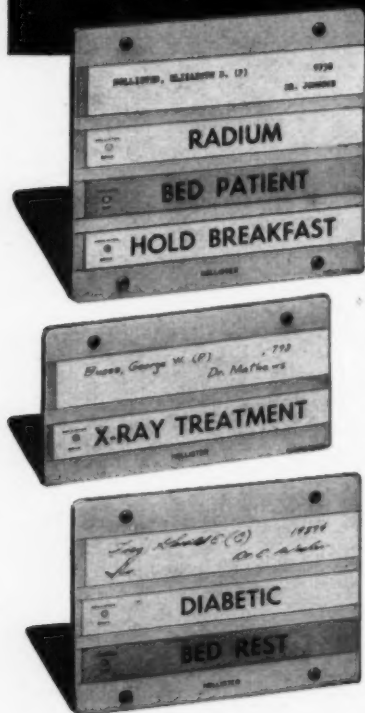
Dans un des articles suivants vous ferez la visite du nouvel hôpital où vous constaterez mieux que je ne pourrais vous le dire ce que la Providence a bien voulu inspirer et faire faire pour un hôpital pour enfants malades.

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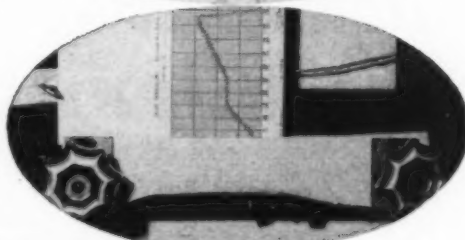
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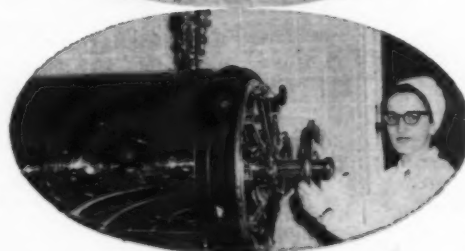
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Medico-Legal Problems

(Continued from page 82)

safe in obtaining the consent of the surviving spouse or, failing one, of the next-of-kin. If there is any reason to suspect that differences exist between two factions of the deceased's family, the hospital authorities would be wise to withhold a post mortem examination until legal advice is obtained.

The criminal code provides a maximum penalty of five years in prison for improper or indecent interferences with a body either before or after burial, but it is most unlikely that this penalty would be invoked for the performance of a post mortem examination in a hospital. However, any unlawful interference with the right to possession of a corpse is actionable in damages.

In the case of *Hunter v. Hunter* (1930) 65 O.L.R. 586, the deceased had been a devout Protestant and an Orangeman who formally became a Roman Catholic about three weeks before his death. He made a will expressing a wish to be buried in the place where his wife would be buried,

and she stated that this meant a Roman Catholic cemetery. In his will the testator also named one of his sons as executor and that son claimed the deceased's body for burial in a Protestant cemetery. The wife, a staunch and devout Catholic, asserted her claim that the body be buried in a Roman Catholic cemetery and cited the will as showing the intention of her former husband that this should take place.

The court maintained the son's claim, holding that, as executor, he had a right to have the body for the purpose of burial and an injunction was granted restraining the widow and others from interfering with that right.

Refusal to Submit to Treatment

(a) Refusal by an adult. If an adult is of sound mind and capable of appreciating the situation and its implications and he refuses to consent to an operation or other treatment, the hospital cannot legally oblige him to undergo it.

In such a case you should have the patient sign a release form (if satisfied that he is *compos mentis*)

relieving the hospital and its staff from any and all liability for injury that may result from lack of the recommended treatment. Such a form could read simply: "Notwithstanding advice and explanation, I have refused to consent to the recommended operation or treatment and fully realize the danger that may result." If in doubt about the patient's sanity, you should have him examined by a psychiatrist.

(b) Refusal followed by emergency. If the patient refused treatment (e.g., a blood transfusion) and later loses consciousness and his condition becomes critical, it is suggested that the hospital and its doctors are justified in proceeding with the transfusion regardless of the patient's attitude before his condition deteriorated.

It is difficult to believe that any court could condemn a doctor for taking steps to keep a patient alive when that patient is no longer in any condition to be consulted and his life is in danger.

(c) Parents' refusal of treatment for their child. You are protected by statute and by common law for

(Continued on page 108)

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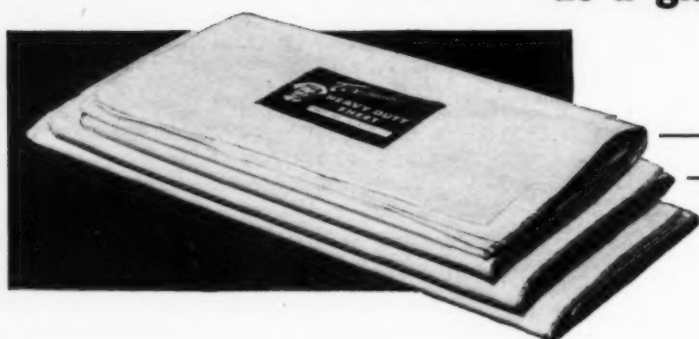
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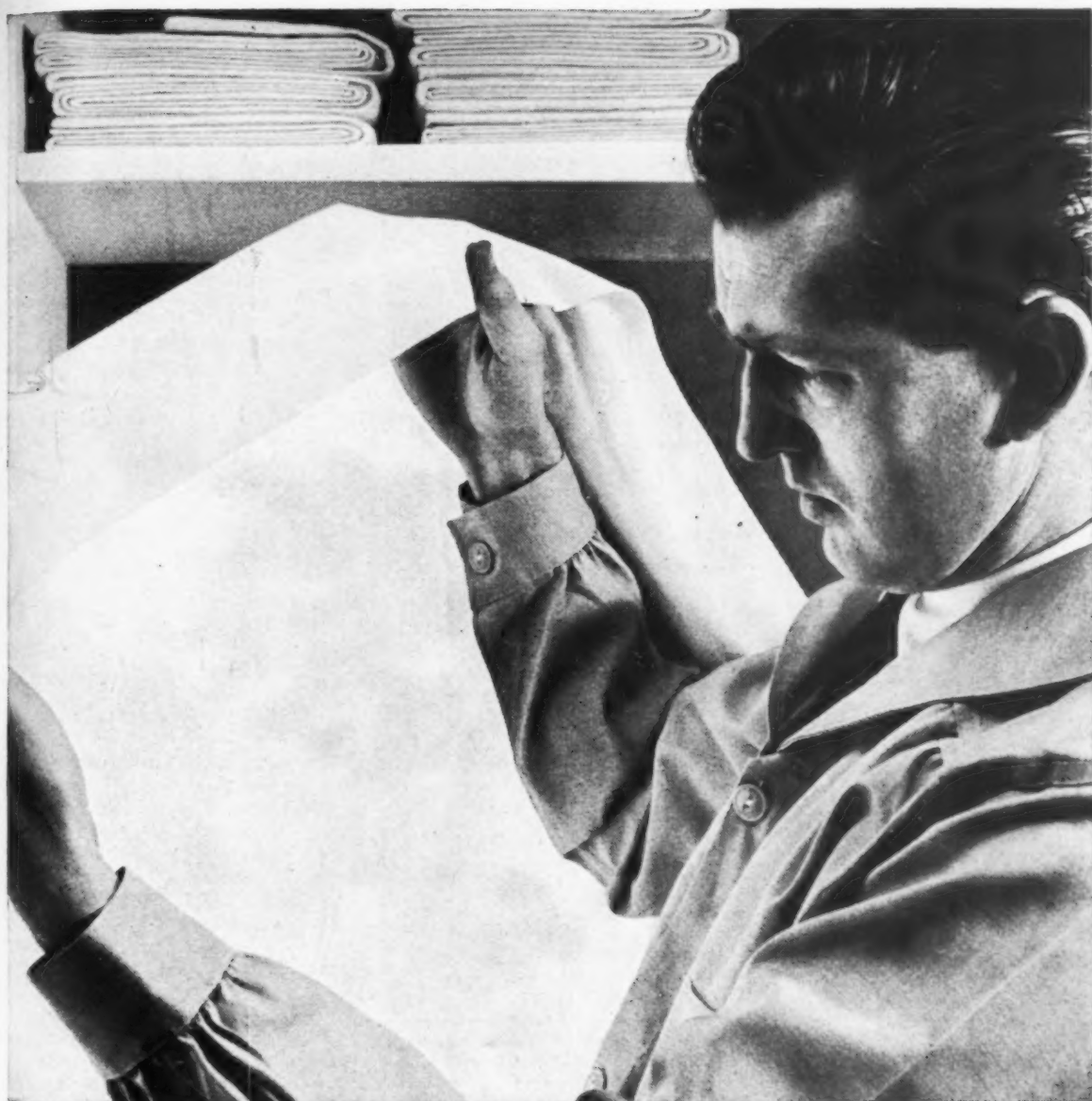


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SEPTEMBER, 1958

107

Medico-Legal Problems

(Continued from page 104)

promptly giving a child necessary treatment (e.g., a transfusion) regardless of the refusal of the parent to give his or her consent to the procedure. The *Lancet*, vol. 1, 1951, (May 5) p. 1012, cites an English case where a child died because the mother refused to permit an operation. The coroner at the inquest told the jury that they might have to consider returning a verdict of manslaughter or even murder, but the jury was extremely sympathetic and found that "the mother did not sufficiently understand what was being asked of her". In England, as far back as 1899, Lord Chief Justice Russell of Killowen, in *R.v. Senior*, tried a

case where the parent belonged to a religious sect known as "The Peculiar People", and he had objected on religious grounds to the calling in of medical aid or the use of medicine for his child. Lord Russell said: "Neglect is the want of reasonable care, that is, the omission of such steps as a reasonable parent would take—such as are usually taken in the ordinary experience of mankind."

Respondeat Superior

This is the latin name for a long-established legal principle whereby a master is liable for the acts of his servant over whom he has the control or the right to control, and whose acts are done within the course of his employment.

This is a large branch of the

law and it is impossible to go into the details of it at this time. However, as a general rule, the hospital board must consider that it will probably be held liable for damages resulting from the negligence of any of its professional staff during the course of their hospital duties.

In *Petite v. MacLeod and Saint Mary's Hospital* (1955) 1 D.L.R. 147, the Nova Scotia Supreme Court stated the law as follows: "A hospital is liable for the negligence of doctors and nurses who are in its employ. It is not liable for the negligence of doctors who have been engaged to operate by the patient and who are paid by the patient, notwithstanding the fact that they make use of the operating room and nurses of the hospital. Where nurses employed by the hospital take part in operations performed by doctors not so employed, the hospital remains liable for any negligence of the nurses in carrying out functions which are properly routine nursing duties."

In the *Vancouver General Hospital v. Fraser* (1952) 3 D.L.R. 785, the court held the hospital to be liable for the death of the patient due to the negligence of an intern who discharged the patient with a broken neck because he was unable to diagnose the fracture on the x-ray and failed to call a radiologist who was available.

With regard to special duty nurses, the general rule is that a special nurse is the employee of the patient and not of the hospital. Therefore the hospital board is not liable for her negligent acts or omissions while carrying out her duties for her employer, the patient. However, the hospital might be considered liable for the negligence of a special duty nurse if she is engaged by a doctor on the medical staff of the hospital, without consulting the patient. In *Logan v. Colchester County Hospital* (1928) 1 D.L.R. 1128, the Nova Scotia Supreme Court held the hospital liable for hot water burns caused by the negligence of a special duty nurse, because she was engaged by a doctor on the staff of the hospital, notwithstanding the fact that the patient had later agreed to pay for special nursing services.

In the case of *Crits and Crits v. Sylvester et al*, 1 D.L.R. 2d 502, which was tried before the Ontario

(Concluded on page 112)

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With the Auxiliaries

Community Catering

The auxiliary of the Summerland General Hospital, Summerland, B.C. finds that it is most successful when it "caters" to the community. Banquets, lunches, weddings, graduations—all are looked after by auxiliary members. When a club, organization, or private citizen wants this catering service, they simply contact the president, guarantee the number of guests and state the type of meal to be served. Then a convenor is appointed who calls for volunteers to help with food preparation, table decoration, serving, and, of course, dishwashing.

When turkey—one of the favourite dishes—is requested, members stuff and cook the fowl the day before, and the meat is served cold. Jellied salads and pies are handled in the same manner, but hot vege-

tables and green salads are prepared right on the scene.

This busy hospital auxiliary has catered to a Kiwanis banquet, an agricultural banquet, and a peaches and cream concession booth at the fall fair, as well as to wedding receptions, a graduation banquet and a Masonic dinner. Working in a spirit of friendly co-operation, the Summerland auxiliary has made this service one of its main fund raising projects.

Funarama Fair

The third annual Funarama held by the women's auxiliary of Smiths Falls Public Hospital, Smiths Falls, Ont., was rated as the most successful so far. There were games, fortune telling, pony rides, refreshments, and some exhibition dancing by the students of a local dancing school. The proceeds amounted to \$3,200.

Among the contributions made to the hospital by this active auxiliary (which, by the way, sponsors a monthly paper collection) are \$100 per month toward the operating costs of the hospital's laundry; donations of \$1,000 and \$2,000 to the new addition building fund; \$1,800 to furnish a new dining room; \$1,400 to furnish a semi-private room; \$1,000 to furnish a laboratory, and so on. Their festive Funarama will help the auxiliary to achieve still more.

Opportunity Knocks

This is the month that the women's auxiliary of Peel Memorial Hospital, Brampton, Ont., has chosen for its giant, all-day "opportunity sale". For some time, the ladies have been busy collecting suitable objects for the sale—relying heavily on the well-known fact that most people, when they finally decide to discard an old possession, would love to have someone take it away as soon as possible.

Broken furniture has been repaired and renovated for the sale, and old hats have been transfor-

(Concluded on page 112)

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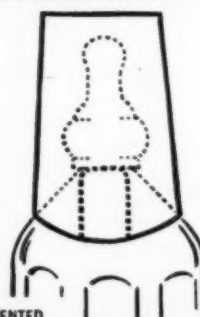


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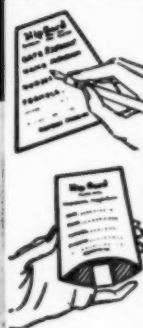
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Auxiliaries

(Concluded from page 110)

ed into smart, fall creations through the efforts of three milliners. The sale—a \$1,000 auxiliary project—provides an ideal opportunity both for getting rid of old, unwanted articles, and for picking up attractive new items at bargain prices.

Bread Baking Contest

Langley Memorial Hospital, situated in the small farming community of Langley, B.C., has benefited this year through the centennial project of its women's auxiliary. Searching for an idea that would appeal to the residents of this rural district, the auxiliary members decided to hold a bread baking contest.

Sponsored by Purity Flour Mills, the contest added over \$100 to the auxiliary treasury. One hundred and seven entries were received, and everyone participating enjoyed an entertaining day. Tempting loaves of bread were, of course, the centre of attraction, but there was also a game called "Cake Walk", a pleasant luncheon, and an evening

of festivities presided over by a master of ceremonies.

And guess who took the first three prizes? Members of the Langley Memorial Hospital auxiliary.

Indoor Garden Party

Cool, damp weather didn't spoil the fun when the ladies of Winchester and District Memorial Hospital, Winchester, Ont., staged their tenth anniversary garden party. They simply substituted the local community centre for the spacious hospital grounds, and held their party inside.

A rousing beginning was provided by the Winchester Cub Pack's Safety Patrol, which marched through the streets to the centre, in time to the music of the high school band. Later in the day the band provided entertainment at the party; in the evening the Salvation Army band took over. Colourful booths and floral arrays dressed up the inside of the building, and a large number of carnival-like displays were provided for visitors.

This year's party may have been cut off from the sun and foliage of an actual garden, but spirits remained high, high enough to net

this successful auxiliary over \$1,500.

Medico-Legal Problems

(Concluded from page 108)

Court of Appeal in January 1956, it was held that the anaesthetist was negligent and the cause of a static electricity-anaesthetic explosion which injured the infant plaintiff who was being operated upon. In this case it was held that the hospital is not liable if the anaesthetist employed by the patient (and not by the hospital) failed to use certain equipment available at the hospital so as to avoid injury to the patient. The hospital is not required to have overseers at hand to watch the use of appliances by qualified men (this anaesthetist was a qualified specialist in anaesthesiology) who are privately engaged.

The English Court of Appeal in the case of *Roe v. Minister of Health*, (1954) 2 W.L.R. 915, held that the hospital was liable for damage caused by the negligence of a specialist-anaesthetist who was paid by the hospital on a part-time basis.

(To be concluded next month)

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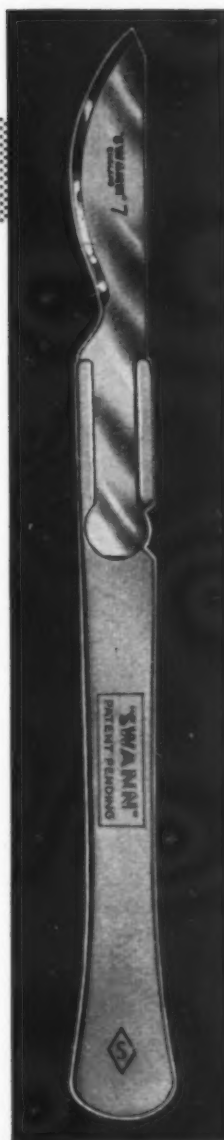
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Preparing to Move

(Concluded from page 44)

ing, credit, claims, out-patients (administrative section), purchasing, and medical records—in order to discuss office lay-outs and the use of pneumatic tubes, conveyors, and inter-communication systems in their particular fields. Many outside firms were also consulted and many visits to hospital offices were organized.

Prior to moving to our new quarters, the committees and sub-committees had studied all the

angles of their particular field, had prepared reports on their findings, and made recommendations to the board of administration. The board knew, therefore, in advance the number of personnel each department required and the amount of wages and salaries that would have to be paid. Rates for board and auxiliary services were based on these estimates.

All the hospital's forms were reviewed over a period of three years by a special committee. Various plate addressing systems as well

as dictating equipment were also investigated by the committee. We finally adopted systems which we feel are best suited to our requirements.

Despite all the care taken in planning ahead, there is always some adaptation to be made when the plans are finally tested in actual operation. Ste-Justine was no exception. First of all we had not realized that the administrative departments would lie so far apart from each other. In the old hospital on St. Denis Street, a two-minute walk took any one of us to any of the administrative departments. On account of the distance, we soon found out that we had to plan our visits to departments in order not to waste any time. Many meetings had to be held with the various heads of the departments in order to discuss the new clerical and mechanical features which had been incorporated into the new hospital.

After but eight months in the new hospital, we look with satisfaction on the degree of organization we have been able to achieve, thanks to our well-defined program and the co-operation we have received from everyone. There is no doubt that, in time, our administrative organization will have reached an extremely satisfactory level.

We are very proud of our organization and we welcome any opportunity we have of explaining our procedures and taking visitors around our various departments.

Rehabilitation

(Continued from page 50)

patients. Surgical ocular correction and optometric services are also used more and more frequently, as are the dental and orthodontic services.

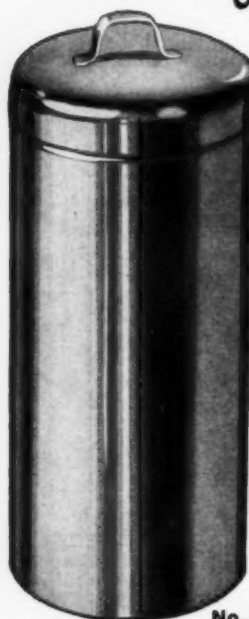
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(Concluded on page 116)

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Rehabilitation

(Concluded from page 114)

present we have four men employed full-time in a most up-to-date and spacious shop. It is located very close to the physiotherapy and orthopaedic out-patient departments. Almost any type of appliance required in a children's rehabilitation centre is made from a plaster moulding of the part of the body concerned. Celluloid splints or shells, arch supports, walking braces and corsets are fitted daily to handicapped youngsters. Even artificial limbs are now being made in our own brace shop. It must also be noted that the cost of these braces is less than that of manufactured appliances.

This account of the rehabilitation services would not be complete without mention of the aid received from the province of Quebec Society for Crippled Children which daily transports the handicapped patients to the clinic, and also runs the summer camp where many of our children spend a very valuable month. The Cerebral Palsy Association of Quebec has also helped in the organization

and maintenance of the cerebral palsy clinic which is integrated in the rehabilitation set-up. — *Pierre Labelle, M.D., F.R.C.P. (C) and Albert Royer, M.D., F.R.C.P. (C), F.I.S.H.*

Cardio-Pulmonaire

(Suite de la page 60)

les valeurs en cours par l'intermédiaire d'un système d'intercommunication.

Galvanomètres et camera sont montés sur un chariot (fig. 6). Cette organisation a pour but de nous permettre d'aller à la salle d'opération. Ce laboratoire mobile fournit au chirurgien la possibilité d'une évaluation objective et quantitative de ses gestes, ce qui représente un guide complémentaire très utile dans les interventions à ciel fermé.

En plus de ces procédures de routine, le Service de Physiologie Cardio-Pulmonaire a mis au point une méthode de cathétérisme du coeur gauche par ponction trans-thoracique dorsale, une technique permettant l'oxymétrie intra-cardiaque continue (circuit fermé comprenant, un manomètre, un

oxymètre à cuvette et une pompe circulante) sans perte de sang pour le patient, un appareil cardio-pulmonaire artificiel pour la chirurgie intra-cardiaque à ciel ouvert, enfin une unité mobile de "ressuscitation cardiaque" disponible pour tout l'hôpital.

English Summary

Major progress in physiology, surgery and anaesthesiology, within the past fifteen years, has made the story of congenital heart malformations one of the best known and interesting chapters of cardiology. Patients with such heart disease might show cyanosis and/or dyspnea. Sometimes, cardio-pulmonary function tests are necessary for differential diagnostic purposes. Among them, cardiac catheterization is a procedure we use at Ste-Justine, because we feel that if such an examination is indicated, the patient deserves the method likely to give the most detailed findings.

Special techniques and apparatus for routine catheterization and recordings in operating room are described here.

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Mind over Matter

(Concluded from page 86)

psychiatrist for his solution to emotional ills, he answered that many psychosomatic illnesses could be prevented—if we could love. Many people do not know the meaning of the word. Love is not possessive. It is not trying to change the other person into your own image of what they should be. Love is willingness to grant the other person full right to his unique humanness. Rather than a matter of aggression and possession, sex should be an avenue of expression of love between man and woman. True love means an integration of personalities, a passionate interest in the other's hopes, ideals and aspirations, and a high regard for the other's dignity and worth.

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SEPTEMBER, 1958

119

Physiotherapy

(Continued from page 80)

Table 17

Percentage of Total Floor Space Allotted to Gymnasiums Reported to be Adequate in Physiotherapy Departments in General and Special Hospitals* Classified by Size of Hospital.

Type of Hospital	Size of Hospital											
	Beds 1 - 199				Beds 200 - 499				Beds 500 and Over			
	Number Reporting	Total Space	Total Gymnasium Space	Per cent	Number Reporting	Total Space	Total Gymnasium Space	Per Cent	Number Reporting	Total Space	Total Gymnasium Space	Per Cent
General	7	9158	3453	38	9	22380	6348	29	12	69997	17052	24
Special	5	14378	6917	48	3	10186	5456	53	6	35899	19439	54

*Special hospitals are Armed Forces, D.V.A. and Rehabilitation Centres.

calculation of figures submitted. Because of the interest in these costs shown by some hospitals who went to considerable trouble and expense to provide valid figures, it is felt that hospital administrators would welcome further study of this subject.

It is important to know not only the cost of running the physical plant, including capital expenditure, depreciation and maintenance,

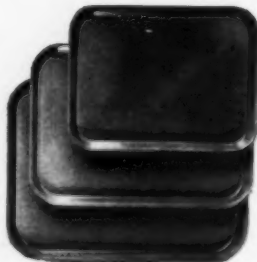
and the therapists' salaries, but also the cost of the auxiliary personnel. Many departments are known to be making use of trained physiotherapists for secretarial work. Thus the time they can devote to their profession is reduced. While this may have little effect on the running cost, owing to the close approximation in salaries in the two groups, it is felt that this is an undesirable waste of trained

personnel whose training is both long and expensive. The Dominion Bureau of Statistics' report on expenditure and revenue in departments of physiotherapy is very interesting, but not sufficient for our purpose.

Throughout the country, the distribution of physiotherapy departments which are not staffed by qualified therapists, and of hospit-

(Concluded on page 122)

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Physiotherapy

(Concluded from page 120)

als which are giving physiotherapy without having a department or a qualified therapist, is especially interesting when one considers that many provinces have legislation to prevent these situations. Some hospitals are known to have tried and failed to attract qualified therapists. Others, in good faith, are employing unqualified therapists because they are under the impression that these are qualified.

Unfortunately, there are still others, fully aware of the requirements, which are not insisting on the employment of qualified therapists even when available. Twelve general hospitals, having 200 beds or over and presumably understanding the use of physiotherapy—because they report to the Dominion Bureau of Statistics that they provide four or five physiotherapy techniques—have neither a physiotherapy department nor fully qualified therapists.

In conclusion, from the returns submitted by the hospitals and special centres and from the notes which have accompanied some of these returns, it is known that many hospitals are at present engaged in building new departments and that the demand for qualified therapists is increasing. During the past three years there has been an increase of 24.5 per cent in the number of therapists employed. Last year the Canadian Physiotherapy Association increased its membership by 210, and many more therapists are working who have not become members of the Association, although qualified to do so. This increasing demand is a direct result of the appreciation by hospitals, doctors and the public, of the rôle of the physiotherapist in helping both to shorten the stay of patients in hospital and to reduce their time away from work.

The figures contained in this article may well indicate room for improvement in many physiotherapy departments. This opinion may be either confirmed or modified by future surveys, but it is probable that such findings will not substantially alter the general picture. In any event, it is hoped that this study will be of material assistance to those who wish to establish departments or improve existing physiotherapy services.

Chesley Cherub

About 60 gifts were presented to little Dinah Lee Thompson recently—just for being born. Dinah Lee was the 1,000th baby delivered in Chesley and District Memorial Hospital, Chesley, Ont.; before she even came upon the scene, she was a local celebrity.

The idea for a celebration of the arrival of the hospital's 1,000th baby came from the hospital superintendent and was taken up with enthusiasm by the hospital board and the women's auxiliary. The chamber of commerce joined in, and soon Chesley business men became interested. The result was a shower of presents donated to the infant. Chesley is obviously very proud of its hospital which becomes ten years old this year.

Strangely enough, the first baby born in the hospital shortly after its opening ten years ago was also named Thompson. Dinah Lee is no relation. But one wonders—will the 2,000th baby be a Thompson too?

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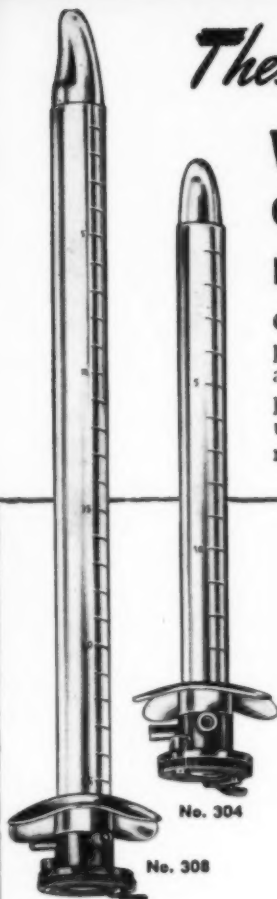
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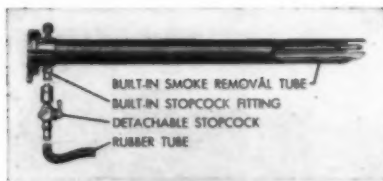
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Provincial Notes

(Concluded from page 90)

it is expected that their use will considerably reduce tray servings.

Alberta

A 25-bed hospital, costing about \$275,000, was opened recently in Cold Lake. One project in a major improvement program (which will also provide a water and sewer system and a new and modern school), the hospital stands near the wooden frame building that it replaces. It was planned that the former hospital be moved to the centre of town to serve as a rooming house. The present hospital, which is a low, two-storey structure of rustic wood and brick, offers fine new facilities and greater comfort to patients.

Tenders have been called by the Bassano Municipal Hospital board for construction of a new 30-bed hospital.

British Columbia

Charles R. Brown, chief of the

Lytton band, became the first Indian to be appointed to the board of directors of St. Bartholomew's Hospital, Lytton, B.C. The hospital was established some 90 years ago as an Indian mission hospital, but was later expanded to include all citizens. Mr. Brown will represent his people as he helps guide the policies of the community hospital.

The city of Prince Rupert has granted \$15,000 to the Prince Rupert General Hospital, to be used to equip the new maternity ward and the third floor west wards, and to provide nursing equipment in the wards and throughout the hospital. The city's grant is part of a \$39,113 program to provide the renovated hospital with new equipment.

Sixty beds are to be provided in the new Kimberley and District General Hospital, Kimberley. Architects Smith and McCulloch of Trail have prepared the plans which call for two main floors with basement. Cost is estimated at some \$1,165,000.

Tenders have been called for construction of new buildings and

alterations to existing buildings for mechanical services at Vancouver General Hospital, Vancouver. Recently this hospital was honoured by the presentation of a bronze plaque for the excellence of its annual report, awarded by the publishers of *Hospital Management*.

C.S.R.T. Convention

(Concluded from page 94)

has rendered to the society; the George Reason cup to Arthur King, London, Ont., for the best exhibit; a prize of \$100 to Edna Dobson, essay award winner; and the Welch Memorial plaque to L. J. Cartwright for the Welch Memorial paper.

Induction of the new president, M. A. McMillan, Vancouver, B.C., brought to a close the formal portion of the program; the evening concluded with dancing in the ballroom. The 16th annual convention was over.

The 1959 convention will be held at Queen's University, Kingston, Ont.

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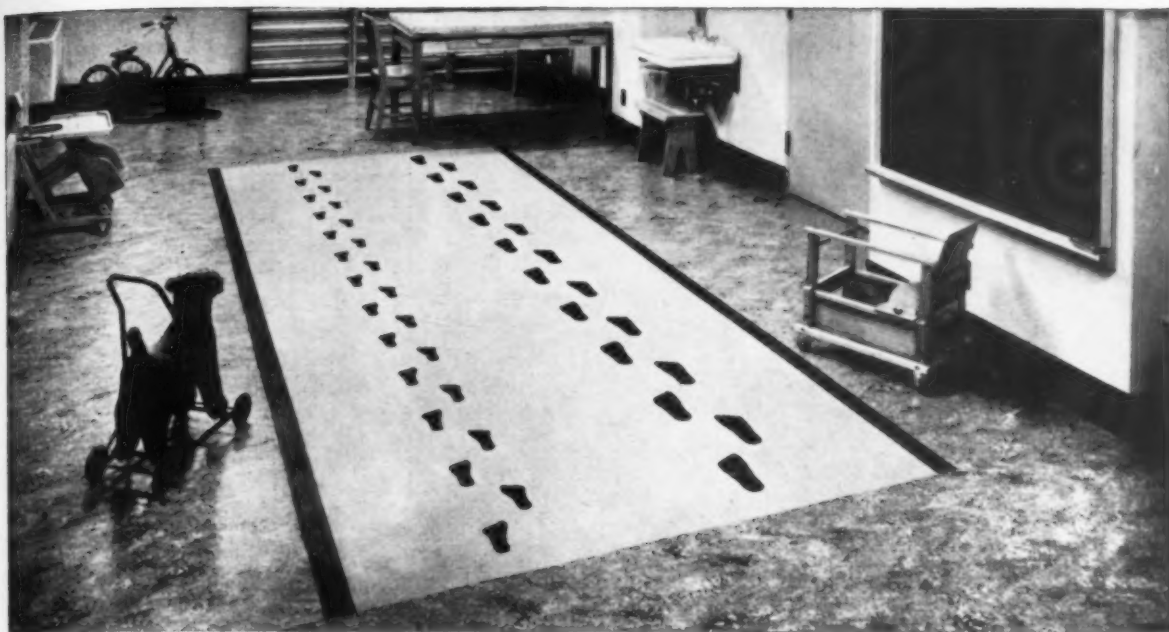
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Twenty Years Ago

From the Canadian Hospital,
September 1938

Dr. Malcolm MacEachern is quite cheery these days. He has been notified that the Roosevelt-Dupont grandchild made its safe arrival with the assistance of the MacEachern obstetrical table at the Pennsylvania Hospital in Philadelphia.

Dr. MacEachern made a flying trip to Germany and England a few weeks ago on the Queen Mary, in order to attend meetings of the Council of Arrangements of the International Hospital Association and the United Kingdom Council. His friends hoped that he would utilize the trip over as a brief and much needed holiday, but, when the ship docked four days later, the letters written by "Mac" in that interval just filled one mail bag!

Visitors to Montreal should see the excellent museum of moulages at the Hôpital Notre Dame. These have been prepared for Dr. A. Marin, the noted dermatologist, by Mlle. Madeleine de Courvel. These models, which are quite the equal of any seen anywhere, received the award of merit a year ago at the scientific exhibit of the Canadian Medical Association.

Incidentally, in the same hospital, the radio has been found to be of definite value in calming patients taking fever therapy. When the temperature rises, the patient is apt to become restless and, sometimes, mentally agitated. This condition responds very quickly to radio programs carefully selected to hold the patient's interest.

Ontario Lumbermen's Association plans to make definite changes in the care of the sick in lumber camps. A headquarters to supervise administration of safety and health regulations in that area will be established at Port Arthur, and infirmaries, with a resident physician in charge of each, will be constructed at all major camps. This association operates under the authority of the Workmen's Compensation Act and is endeavouring to overcome the situation in some sections brought about by the failure of physicians, holding contracts and living in cities at some distance, to keep in close touch with the camps under their care. Young physicians are being encouraged to take up residence in the camps.

Fully equipped infirmaries, each with a resident physician, have been erected at Neys and Black

Sturgeon camp, at Pigeon River Company camp, and at the New-aygo Timber Company camp at Hale. A fourth is being built for the Ontario Paper Company at Heron Bay.

Diagnostic Centre From Old Ste Justine

The province of Quebec, which bought the old buildings of Ste Justine Hospital in Montreal, will transform them into the first diagnostic centre to be administered by the Quebec government. Mr. Duplessis has said that one of the important points to note about the new centre is that it will be open to both family physicians and general practitioners.

The Quebec government plans to operate several other such centres across the province, which would put laboratories and other accommodation necessary for diagnostic examination at the disposal of the province's doctors.—*Le Devoir*.

UNICEF Greeting Cards

Attractively designed cards, containing season's greetings in the five official languages of the United Nations, are being made available through the United Nations Children's Fund. Their object is to "let your greetings help a child". The cards come in three types—the United Nations' own "Tree of Peace", two designs featuring Mexican children, and "A Time of Joy", a series of five designs showing children celebrating the festivals of their homelands. Price is \$1.00 for a box of ten 4 5/8" x 5 3/4" cards (also obtainable without the greeting for use as note paper). They can be ordered through the UNICEF Greeting Card Fund, U.N.A. Committee for UNICEF, 280 Bloor St. West, Toronto.

New Eye Bank Opens

The establishment of the Eye Bank of Canada, British Columbia Division, has been announced by Captain M. C. Robinson, CNIB national director for Western Canada, and Dr. John A. McLean, Chief of Ophthalmology at the Vancouver General Hospital and professor of Ophthalmology, U.B.C.

The new eye bank will provide a central storehouse and system for procuring the necessary supply of corneae for corneal transplant operations. Banks are already in operation in Ontario and Quebec where more than 142 transplants have been performed.—*National News of the Blind*.

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(Continued on next page)

Medico-Social Service

(Continued from page 47)

month, then every third week, and after three months, if the baby's condition is satisfactory, one visit a month, for a period of one year. The mother is invited to attend the post-natal clinic in order to obtain information concerning the diet of her baby and the immunization of her child. B.C.G. vaccination is also available on request of the parents or of the paediatrician.

If the mother feels her baby is not well and telephones the department, a nurse visits the home the next day or advises immediate consultation at the hospital and, when necessary, the child is hospitalized.

The medico-social service is particularly interested in the care of the premature baby, and never hesitates to supply all the information requested for this category of patients. As these cases are becoming more and more numerous and require very special care, an additional nurse has recently been added to the staff to look after them.

Placements

The principal aim of the section, whose special duty is "inquiries and placements", is to help the patient who has personal problems regain and conserve his health. These patients are referred to us by their physicians, by other hospitals and social services and by their own family.

The usual cases are patients, of interest to other social services, who are referred to us to be treated and medically observed during the required period.

This service section also advises the parents when special treatment is necessary in other institutions, and is constantly in contact with the special social services who look after families, when the mother does not receive proper care or the father is too ill to provide for his children.

Special public hygiene problems may also arise, requiring long periods of observation and special education of the mother.

It is often necessary to find some institution, when required, for a reasonable period of convalescence.

Incurable mental cases have to be placed. This presents a difficult situation because of the lack of proper institutions to take care of these children.

The CANADIAN HOSPITAL

It is sometimes necessary to provide for hospitalized children who have been abandoned by their family.

Care must be taken to avoid unnecessary repeated hospitalizations.

Patients whose homes are outside Montreal must, in some cases, be referred to outside social services.

The Future Mother

The pre-natal, natal and post-natal departments, as well as the outdoor obstetrical clinic, are very much linked together and are in constant contact with the medico-social service on our adult level. These departments are very much concerned that the mother of the baby receives proper advice.

It may be noted that the first contact with the future mother often permits the social worker to determine certain existing family or economic problems. When confidence has been established on both sides, the future mother will often admit that she has other problems which the social worker will help her to work out. The social worker with her experience and her proper approach can help the patient to help herself. She can dispense profitable advice and encouragement and always manages to see the patient when necessary.

In Orthopaedics

The orthopaedic section of the medico-social department is in contact with the orthopaedic service, and the social worker consults with the orthopaedic surgeon, the patients and the personnel of the "brace workshop". The surgeon prescribes the brace to be made in the workshop, but the patient will obtain his apparatus only if the social worker sees that it is possible for him to obtain it, as most patients must receive help from one of many sources with which the hospital is in contact.

The Choice

A bachelor who had to choose between a very beautiful girl who couldn't boil water and a girl who was homely but an excellent cook decided on the girl who could cook. The morning after the wedding he was the first to wake up. The sun streamed in the window, outlining her features sharply. For a moment he looked at her, then he shook her and said, "Mabel. Get up quick and cook something."

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TELEPHONE
BELMONT 3-9511

Coming Conventions

- Sept. 15-18—Canadian Association of Medical Record Librarians, 24th annual convention, Quebec City, Que.
- Sept. 15-19—Western Institute for Hospital Administrators and Trustees, Royal Alexandra Hotel, Winnipeg, Man.
- Sept. 24-25—Catholic Hospital Conference of Alberta, annual meeting, Edmonton, Alta.
- Oct. 15-17—The Saskatchewan Hospital Association, annual meeting and institute, Bessborough Hotel, Saskatoon, Sask.
- Oct. 18-19—The Catholic Hospital Conference of Saskatchewan, annual convention, Saskatoon, Sask.
- Oct. 21-23—Annual convention of the Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alta.
- Oct. 26-27—Catholic Conference of British Columbia, annual meeting, St. Paul's Auditorium, Vancouver, B.C.
- Oct. 27-29—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.
- Oct. 28-31—Annual convention of the B.C. Hospitals' Association, Hotel Vancouver, Vancouver, B.C.
- Oct. 30-31—Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto, Ont.

Hospital consultants

AGNEW, PECKHAM AND ASSOCIATES

Consulting Services in Hospital
Planning, Organization and Management
Hospital and Community Surveys

Harvey Agnew, M.D., LL.D., F.A.C.H.A.
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200 St. Clair Ave. W.,
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Classified Advertising

Operating Room Supervisor

for

Saint John General Hospital,

Saint John, N.B.

400 bed hospital

with

School of Nursing — 150
students.

Qualifications: post - graduate
certification in operating room
technique and management
with experience.

Apply to

Director of Nursing,

Saint John General Hospital,

Saint John, N.B.

Wanted Immediately

Physician to fill position of
Medical Director for large 800
bed General Hospital. Must
also assume position as Di-
rector of Medical Education for
active interne teaching pro-
gram. Applicant should have
administrative ability and
medical qualifications for
graduate teaching. Salary de-
pendent on experience and
educational background. Ap-
ply with full particulars to
Chairman, Board of Governors,
Regina General Hospital, Re-
gina, Saskatchewan.

Director of Nursing Education Wanted

For 500 bed general hospital with
a School of Nursing. Applicant must
have a degree in nursing. Salary
commensurate with experience and
qualifications. Apply to, Director of
Nursing, Royal Jubilee Hospital, Vic-
toria, B.C.

Pharmacist Required

For 300 bed general hospital. Apply
to Chief Pharmacist, Hotel Dieu Hos-
pital, Kingston, Ontario.

Dietitian Wanted

Assistant to chief dietitian required
for new 250 bed General Hospital.
Modern Dietary Department, Cafe-
teria and trayveyor service. Excellent
working conditions and personnel
policies. Full details of position avail-
able to applicants. State qualifications
and experience. Apply to Chief Dieti-
tarian, Sudbury Memorial Hospital,
Sudbury, Ontario.

Dietitian Wanted

For 75 bed hospital, to take charge
of dietary department and teach
dietetics in the School of Nursing
(approx. 35 students). Excellent
working conditions, personnel policy
and salary. Apply to A. J. Schmiedl,
Administrator, Dauphin General Hos-
pital, Dauphin, Man.

Graduate Pharmacist (Assistant)

Required at Hotel Dieu of St.
Joseph Hospital, 382-bed hospital with
building programme in progress.
Please submit all applications in
writing to: Sister R. M. Prieur, Asst.
Administrator, Hotel Dieu Hospital,
Windsor, Ontario.

Purchasing Agent Required

For a 300 bed general hospital in
southern Quebec. Purchasing expe-
rience in hospital field necessary. Sal-
ary commensurate with qualifications
and experience. Apply Box No. 902S,
The Canadian Hospital, 57 Bloor
Street West, Toronto 5.

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes
inquiries from Hospital Trustee and
Administrative and Department Head
Level Personnel for Hospital and
Medical Group positions.

Dr. Johnson is trained and experi-
enced in Hospital administration as
well as Personnel Management and
is available for Consultation of Per-
sonnel needs.

Our files contain many well quali-
fied personnel as well as interesting
openings.

We pride ourselves on careful
screening of all clients and thorough
investigation of openings. Our aim:
to match the applicant and the spe-
cific position.

MARY A. JOHNSON ASSOCIATES

11 West 42 Street, New York 36, N.Y.

Mary A. Johnson, Ph.D., Director

Accountant Wanted

For 300 bed general hospital, cap-
able of keeping general ledgers, tak-
ing off financial statements and re-
turns. Please send full details and
references to P.O. Box 64, Kingston,
Ontario.

Position Wanted

Graduate of Extension Course in
Hospital Organization and Manage-
ment, with 9 years of varied hospital
experience, seeks position as Assist-
ant Administrator. Please write to
Box No. 913K, Canadian Hospital
Journal, 57 Bloor Street West, Tor-
onto 5, Ontario.

CANADA'S CHEMICAL VALLEY Sarnia, Ontario

Director of Nursing Services

Required for modern, fully approved (JCAH) 300-bed well equipped
hospital.

This progressive industrial city of 45,000 is growing; it is a summer
resort area located on the shores of Lake Huron and the St. Clair
river.

The hospital has approved schools for nurses, laboratory tech-
nologists, x-ray technicians, and is approved for intern training.

Qualifications for applicants include registration in Ontario, at least
a bachelor's degree in administration, and successful experience in
the field of nursing education as well as in nursing administration.

For more details and literature concerning the position and Sarnia,
write to:

Personnel Director

Sarnia General Hospital

SARNIA, ONTARIO

ROYAL VICTORIA HOSPITAL SCHOOL OF NURSING

MONTREAL, QUEBEC

Postgraduate Courses

1. (a) Six month clinical course in Obstetrical Nursing.

Classes — September and February.

- (b) Two month clinical course in Gynecological Nursing.

Classes following the six month course in Obstetrical Nursing.

- (c) Eight week course in Care of the Premature Infant.

2. Six month course in Operating Room Technique and Management.

Classes — September and March.

3. Six month course in Theory and Practice in Psychiatric Nursing.

Classes — September and March.

Complete maintenance or living-out allowance is provided for the full course.

Salary—a generous allowance for the last half of the course.

Graduate nurses must be registered and in good standing in their own Provinces.

For information and details of the courses, apply to:—

Miss H. M. Lamont, B.N.
Director of Nursing,
Royal Victoria Hospital,
Montreal, P.Q.

Classified Advertising

continued

X-Ray Technician

For Canton, N.Y., hospital, to take charge of small x-ray department. Alternate night and week-end call duty. Salary commensurate with experience and ability. Apply: Leon Bennett-Alder, Administrator, North County Hospitals, Inc., Gouverneur, N.Y., U.S.A.

Wanted

Nurse Superintendent for 50 bed hospital. Preference given to nurse having post graduate training in Hospital Administration. Please state past experience, age, salary expected, etc. Personal interview invited. Apply to: Stanley Acheson, Chairman, Centre Grey General Hospital, Markdale, Ontario.

Dietitian Wanted

Dietitian required by December 1st, for 114 bed general hospital. Good working conditions and personnel policies. Reply giving details of personal history, training and experience to Administrator, Powell River General Hospital, Powell River, B.C.

Director of Nursing

New modern general hospital in Northern Ontario requires Director of Nursing, duties to commence November 1, 1958. 42 adult beds, 11 bassinets. Must have experience as Director or Assistant Director of Nursing.

Salary Range \$349.00 to \$469.00 monthly. Welfare benefits available. Give details of training, experience, post graduate studies, and references in letter to—Administrator, Anson General Hospital, Iroquois Falls, Ontario.

General Staff Nurses

All shifts. Salaries range from \$220 to \$265, with good personnel policies which include a 40 hour week, paid sick leave, and holiday time. For a small modern general hospital where there are medical, surgical and obstetrical services. Apply: Director of Nursing, Edward John Noble Hospital, Alexandria Bay, New York, U.S.A.

A. B. C. COLOSTOMY

2—Guaranteed

There is a one year warranty on A.B.C. equipment. (Elastic excluded)

1—Simple

Quick and easy pouch changing made possible by A.B.C.'s exclusive feature.

3—Odorless Sanitary

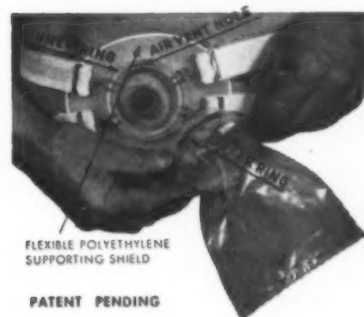
The plastic rings and pouches covering the stoma are completely odor resistant.

4—Economical Dependable

Made of strong durable plastic assuring long life.

5—Lightweight Comfortable

Weights only 3 oz. sufficient ring depth to protect clothing from stoma.



FLEXIBLE POLYETHYLENE SUPPORTING SHIELD

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WHY THE A.B.C.
COLOSTOMY KIT IS
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11 Brule Gardens, Toronto 3, Ont.

O.H.A. Convention

As mentioned on page 26 of our August issue, the 34th annual convention of the Ontario Hospital Association will be held October 27-29 at Toronto's Royal York Hotel. Further information reports that the style of the convention will be somewhat different this year. In former years all section meetings were held on the second day of the convention, but in 1958 they will be spread out

over the three-day period. In addition to the regular sections which have been meeting annually, the newly-formed housekeepers' section will meet for the first time on Wednesday morning, October 29, in the library of the hotel.

It is now understood that Dr. W. I. Taylor, director of the Canadian Commission on Hospital Accreditation, will be addressing convention delegates at the panel discussion on Wednesday.

O.H.A.—Dietetic Section

The dietetic section of the Ontario Hospital Association convention will be held on October 27 in the Roof Garden of Toronto's Royal York Hotel. The following program has been tentatively arranged. In the morning, there will be three speakers. Dr. A. Rapoport of the Department of Medicine, University of Toronto, and Toronto Western Hospital will speak on "Recent Metabolic Studies". "Renal diseases—their related dietary problems and treatment" will be the topic of Dr. W. T. W. Clarke of Toronto General Hospital. Dr. H. Hoyle Campbell of St. Michael's Hospital in Toronto will discuss "Burns and Plastic Surgery".

The afternoon session will begin at 2.15 with a talk on "Nutrition in Civil Defence Planning" by Dr. L. B. Pett, chief of the nutrition division, Department of National Health and Welfare, Ottawa. The meeting will close with a panel on the subject of "Food Hygiene and Sanitation", to be chaired by Gladys Martin, director of nutrition, Hospital for Sick Children, Toronto.

"On the Way Up"

Schools of practical nursing, vocational counsellors, and others who want to stimulate the interest of young people in practical nursing as a career will be interested in a new recruitment pamphlet, entitled, "On the Way Up". This colour brochure is available from the National Association for Practical Nurse Education, 654 Madison Avenue, New York City, N.Y. In question and answer form, it answers the principal questions in the minds of prospective students.

Single copies may be had free or purchased at \$5.00 per hundred, and the practical nurses' education association will supply, free, an equal number of copies of its latest list of approved schools of practical nursing throughout the United States.

Haiti Helps Malaria Fund

The government of Haiti, in the West Indies, gave a \$5,000 cheque as its contribution to the Special Malaria Fund of the Pan American Sanitary Bureau. Haiti, with P.A.S.B. collaboration, has also successfully completed a campaign for the eradication of yaws.—Pan American Sanitary Bureau.

WABASSO

double-duty sheets



the ONLY SHEET in Canada
designed specifically
for hospital use



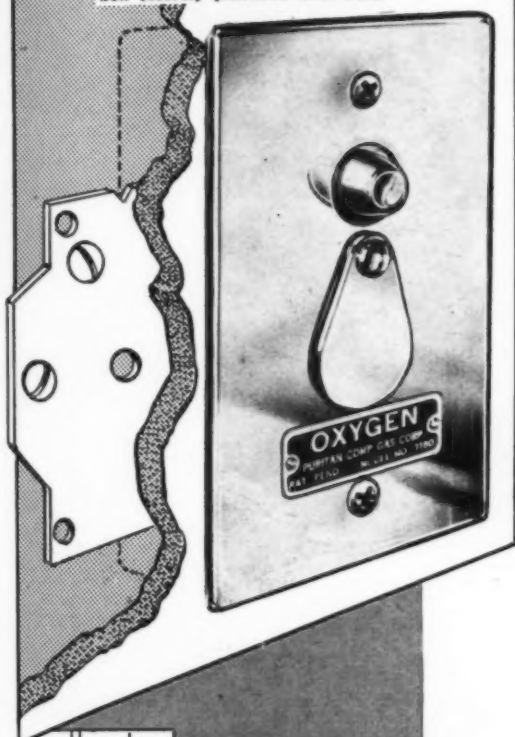
Wabasso Double Duty sheets pay off when the demand is for hard wear and frequent laundering! These heavy quality sheets are tightly woven from fine yarns to give that smooth textured surface so important for hospital or institutional use.

Order through your local
wholesaler or hospital
supply house.

**THE WABASSO COTTON
COMPANY, LIMITED**

Montreal • Toronto • Winnipeg • Vancouver

As installed in Hadite, Concrete Block or Building Tile, with anchor-flanged box securely plastered into wall.



PERMANENT EQUIPMENT PERMANENTLY INSTALLED..

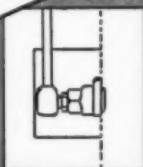
*No damage to walls,
even after years of use*

Because of their unique flange construction which permits them to be literally anchored into the wall, only Puritan station outlets can promise *permanent rigidity* despite the continual strain and pull of such heavy equipment as humidifiers and vacuum bottles. This fact, in addition to new design features which automatically provide the safest, fastest and simplest method of use ever devised, permits you to take full advantage of the tremendous benefits offered by a central supply system.

Ask your Linde representative to demonstrate the quality-engineered features of these new station outlet assemblies for piped Oxygen, Nitrous Oxide, Vacuum service or Compressed Air!

- Available in single or multiple units, for concealed or exposed low pressure piping systems.

POSITIVE GAS SEAL when in use or idle; including the features recommended by N.F.P.A.



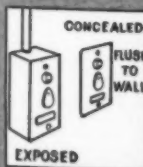
POSITIVE INSTANT CONNECTION No aligning; equipment connects instantly with a straight thrust, with insert-connector a permanent part of the flowmeter. Keyed valves permit only the proper equipment to be connected to any service.



POSITIVE DISCONNECTION A touch to release button unlocks connection and equipment is lifted straight out, simultaneously releasing the secondary safety catch that would prevent accidental dropping if equipment were not firmly held.



PERMANENT RIGIDITY Whether flush-mounted for concealed piping or surface-mounted for exposed piping, Puritan anchor-mountings assure complete and lasting stability through years of continual use.



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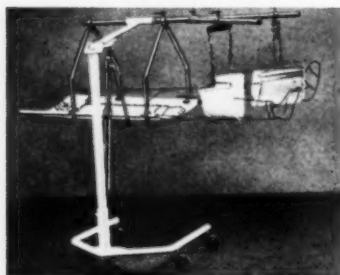


News Released by Hospital Supply Houses

By C.A.E.

Hydraulic "Sick-Lift" Eases Nurses' Work

The hydraulic "sick-lift" enables dangerously ill or paralyzed persons and also patients who have undergone operations to be put into other beds and to be moved or bathed by a single person with the least possible effort. It is an apparatus that may be put to many uses.



The Stiegemeyer "sick-lift" and stretcher, with hydraulic pump, enables patients to be easily lifted and lowered progressively. A plastic cloth available in several designs, which is easily cleaned and disinfected, is placed underneath the patient and caught by the lifting arm of the apparatus. After that, the patient can be hydraulically lifted up for 75 cm, i.e. from 40 to 115 cm above the floor, and wheeled away. By pushing the pump levers the patient can be smoothly lowered to any level.

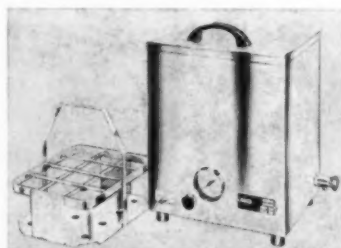
In the operating-room the sick-lift is particularly useful. Before the operation the plastic cloth must be placed underneath the patient. After the operation the sick-lift is brought up to the oper-

ating table, and its auxiliary stretcher is caught by the lifting arm of the apparatus and lifted a little. Now the patient on his stretcher can be easily wheeled to and lowered on to another bed.

Further information is available from Chas. Mehrke, Canadian Agent, 450 Logan Avenue, Toronto.

Combination Bottle Warmer and Sterilizer

The Champagne Electric Company of New Rochelle, New York, has just introduced its new fully automatic combination Bottle Warmer and Sterilizer. The unit is constructed of stainless steel throughout and has dual temperature control maintaining temperature automatically at 105 degrees for bottle warming, or permitting the unit to be used as a regular sterilizer at 212°F. A large dial type precision thermometer permits visual observation.



An extra heavy twelve bottle stainless steel basket is included for sterilization of completed formula or permitting sterilization of bottles in inverted position.

The unit comes complete with

automatic controls, pilot light, low selector switch, cord and plug; wattage is 1000, 110V, AC.

Meals-on-Wheels Speeds Tray Assembly

A new development in the Meals-on-Wheels food service system is the incorporation of two AMF Lowerator Dispensers in the model TA-100 mobile cold tray assembly table. Designed to increase ease in handling butter plates and saucers, the Lowerators have stainless steel coil-spring mechanisms which automatically position saucers or plates at the ideal serving level. Three steel posts extending above the Lowerator well-edge hold the top dishes in alignment to make easy the removal of four or more at once. As each is used, another pops into place, instantly available and within easy reach, even the last one.

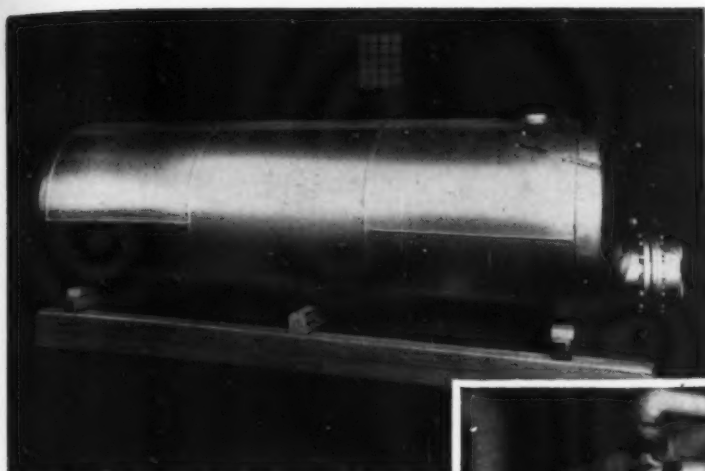


The Meals-on-Wheels model TA-100 assembly table handles trays, glasses, butter plates, saucers, silverware; package items such as iced tea bags, instant beverage packets, condiments, packaged sugar, paper tray covers, napkins; and the standard cold food items—milk, butter, cream, salad dressings, salads, cold dessert (except ice cream), for 100 patient trays. For further information write: Meals-on-Wheels System, 5001 East 59th Street, Kansas City 30, Missouri.

Canadian Lifter Solves Major Problem

Comments and suggestions received from many pathologists have resulted in a solution to a major problem that exists in most morgue areas.

(Continued on page 136)



MONEL hot water storage tank after installation at the Misericorde General Hospital, Montreal.

"17 years of unfailling service and we haven't spent a penny on it"

says M. Bourret,
Chief Engineer,
Misericorde General Hospital, Montreal



MONEL ^{*} HOT WATER TANKS CUT COSTS...LAST LONGER

"Maintenance costs on our steel hot water tanks run about \$30 a year each, and it is necessary to close down the tanks for a day when they are being cleaned." That's the experience of M. Bourret, Chief Engineer of the Misericorde General Hospital in Montreal.

Now hear what M. Bourret says about a Monel tank installed in the same hospital seventeen years ago: "... our Monel tank, which has been in operation since 1941, has never had a penny spent on it."

The Monel tank was fabricated by Darling Brothers Limited of Montreal and installed by J. W. Jette, Ltée. It measures 48 inches in diameter by 12 feet and holds 1050 U.S. gallons. After twelve years of service, the Monel tank was opened for the first time and, as M. Bourret says, "*found to be in perfect condition.*" It was opened again last year and still showed no signs of corrosion, rust or wear.

In comparing costs of maintenance of steel and Monel tanks, M. Bourret noted that the steel tanks have to be coated inside regularly with portland cement; the men work in the tank at temperatures of 140°F. The Monel tank, of course, requires no such maintenance. That's how Monel tanks can save you money, downtime and inconvenience.

*MONEL Nickel Copper Alloy—Trademark Registered

MONEL hot water storage tanks can be obtained from these suppliers:

ELLETT COPPER & BRASS
CO. LTD.
Vancouver

DARLING BROTHERS LIMITED
Montreal

ARTHUR S. LEITCH CO., LTD.
Toronto

FERRO METAL LIMITED
Montreal Toronto



THE INTERNATIONAL NICKEL COMPANY OF CANADA, LIMITED
55 Yonge Street, Toronto

Across the Desk

(Continued from page 134)

Market Forge Company has announced the development of a new Cadaver Lifter, designed specifically for easier handling of cadavers which are stored in the conventional 2 or 3 tier telescoping rack-type mortuary refrigerators.

First tested in one of New England's newest and largest hospitals, the Cadaver Lifter saves considerable time, manpower and eliminates unnecessary physical strain. Now, one person can handle a cadaver with ease on admittance to morgue room or when transferring to autopsy table for post-mortem examination.



Operated by a winch with a leverage ratio of 30 to 1, this mobile equipment has 3 sturdy straps which wrap around cadaver and hook onto a rigid lift bar. All steel construction with non-corrosive enamel finish, it is equipped with 5" diameter rubber-tired swivel casters for silent, smooth mobility.

Further information and catalog sheet on the new Cadaver Lifter can be obtained by writing to Hospital Division, Market Forge Company, Everett 49, Mass.

Literature on Emergency Power System

A new battery powered emergency lighting system for hospital operating rooms is described in Wilmot Castle Company's Section 100.

Known as the Castle No. 582, the new unit prevents "surgical blackout" by instantaneously switching illuminating power to "battery" in the event of power failure. Designed to illuminate both 12 and 18V. lamps, the No. 582 is said to be the first emergency power unit to supply a complete system

of surgical light during power failure. In event of power failure, power is automatically shifted to a system of overhead and portable surgical lights which illuminate the work areas of surgical team members, surgeons, anaesthetists, and nursing personnel.

Copies of the new catalog may be obtained by writing to the advertising manager, Wilmot Castle Company, 1914 East Henrietta Road, Rochester, New York.

R. F. Hutchings

R. F. Hutchings, vice-president and general manager of Corbett-Cowley Limited, passed away in Toronto on August 1st. Mr. Hutchings was a native of Bideford, Devon, England, who came to Canada as a boy. He worked for some years on a farm in the Ancaster district. Later, in Guelph, Ontario, he was connected with the retail hardware business. In 1912, Mr. Hutchings joined the Massey Harris Company in Toronto. He was with this company until October, 1923. He was head ledger keeper.



R. F. Hutchings

In October 1923, Mr. Hutchings joined Corbett-Cowley Limited, a young Company which had started business in July of the same year. Even before joining the Company on a permanent basis, he had helped with the organizational work in his evening hours.

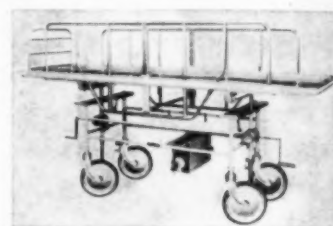
At the time of his death, Mr. Hutchings had been in charge of the Toronto operation of the Company. Mr. Hutchings was familiar with all aspects of his Company's business and had experience in selling, purchasing, managing and accounting. He had travelled in all provinces for the Company and had many friends in hospitals throughout the Dominion.

Stretcher With Oxygen Tank Carrier

An attachable oxygen tank carrier that holds a 20" x 4 1/2" tank for use with the company's post-anesthesia-room stretchers has been introduced by Colson (Canada) Ltd., Toronto, manufacturers of institutional wheeled equipment and a pioneer in the development of post-anesthesia-room equipment.

Through use of this holder, oxygen is always immediately available and can be moved into the PA room along with the patient.

This oxygen tank attachment on the stretcher eliminates the potentially critical time lapse between operating room and the PA room, should oxygen be required.



The attached tank provides greater space for maneuvering and handling by nurses and doctors treating post-anesthesia room patients. The holder, available in both painted and stainless steel models, clamps directly to the lower framework of the stretcher chassis in any location and is now available as optional equipment. It can be attached to any model in the Colson post-anesthesia-room stretcher line.

Details available from Colson (Canada) Ltd., 65 Manser Rd., Toronto 15.

New Hospital Sheeting Wins Enthusiastic Acceptance

After many years of intense research a new improved hospital sheeting has been developed by a large Canadian textile mill, combining the use of polyester fibre and silicone rubber compounds, for use in modern hospitals and institutions.

Primarily, the idea was based on the special qualities of silicone rubber. This inert material is resistant to acids, alkalis, bleaches, soaps, detergents and uric acid. Thus, it was considered possible that a combination of silicone rubber and a fabric base could well form a hospital sheeting which

(Concluded on page 138)



Rada for Showers

*Uniform's off and a naiad's gone
to take a shower with nothing on.*

*If she is wise she will take good care
that Rada's the name the shower valves bear.*

*If she does not she is apt to find
that the cold's not cold and the hot's unkind.
Rada irons out the bumps and keeps*

*things in their places
Complexions count not only where the face is.*

More about Radas in pamphlet No. ZC/98.

WALKER, CROSWELLER & COMPANY, LIMITED

Canadian Office: 16th Avenue East, Markham, Ontario

Telephone: Markham 277

Manager: G. E. STARR

British Office: Cheltenham, England.

Across the Desk

(Concluded from page 136)

would be an improvement on the presently used rubber sheeting.

After prolonged tests, the theory was proved and the finished product was evolved by using a Terylene base fabric which was then coated with silicone rubber compound. Up to this stage, of course, tests had only been carried out in the factory and laboratory. Latter test yardages of the fabric were distributed to a group of representative hospitals and a further series of 'on the spot' tests initiated, which were highly successful.

The high initial strength of the two materials used in manufacture have ensured a fabric, which, in actual use, proves itself to have terrific durability despite far less weight than in the old type hospital sheet. The material has the advantage of being soft and flexible, with no clammy feel, while it is easily cleaned with ordinary detergents or soap.

For further information write Duplan of Canada Limited, 423 Mayor St., Montreal, Quebec.

Bruce M. Hale With Gordon A. MacEachern

The appointment of Bruce M. Hale as sales promotion manager was recently announced by Gordon A. MacEachern, president of Gordon A. MacEachern Limited, floor finishing specialists.



Bruce M. Hale

Mr. Hale was born and educated in Tiffin, Ohio, served as a Pilot Officer in the R.C.A.F., and later as Major with the American Air Force. He has spent the last 13 years in the floor covering industry and is a past president of the Buffalo Floor Covering Association.

R. Perrault Joins G. A. Hardie Co.

R. Perrault has been named sales representative in the province of Quebec for G. A. Hardie & Co. Limited, according to announcement by G. Middleton, sales manager. Mr. Perrault is well equipped for his new position, being bilingual and with extensive sales experience in Quebec. He was form-



R. Perrault

erly industrial district manager for Colgate-Palmolive in that province, as well as having served as junior and senior salesman. He recently resigned from that company and accepted the position with G. A. Hardie & Co. Limited.

Cyanamid Break Resistant Plastic Pipettes

Break-resistant pipettes with the clarity of glass are now available from Plastic Assembled Products, Inc., Baltimore, Maryland. The pipettes (droppers) are moulded of Cymac 201, versatile methylstyrene acrylonitrile copolymer plastic, a product of American Cyanamid Company.

Plastic Assembled Products, reputedly the world's largest manufacturer of dropper assemblies, has supplied the biological and pharmaceutical field with closures and droppers for over twenty years.



The company produces nearly 300 types of droppers, closures, and specialty products.

In manufacturing the pipettes, high speed injection moulding machines form 24 Cymac pipettes at a time in sizes from 1.5 to 3.5 inches.

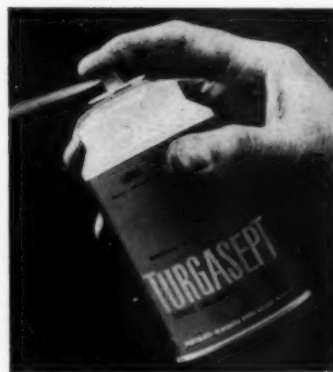
Plastic Assembled Products also moulds coloured closures for their droppers, using Cyanamid's "Beetle" urea moulding compound.

Calibrations are either hot-stamped or silk-screened on the pipettes, depending upon the curvature of the surface, using either foils or specially-developed chemical-resistant paints.

"Turgasept" Is New Malodour Control

"Turgasept", it is claimed, solves the ever present problem of odour correction in the hospital, without formalin, phenolic resins or floral masking. It eradicates odour through ionic fusion—a new concept of controlling malodour molecularly at the microparticle level. Its bactericidal and fungicidal properties reduce air-borne bacteria.

Turgasept Aerosol Spray removes organic as well as inorganic odours in the air. In addition, it removes odours that linger about objects in the room.



Turgasept retains its effectiveness without contributing any sweet floral or disagreeable odours of its own. It remains active long after its pleasant characteristic scent has vanished. Turgasept Aerosol is always handy, ready and easy to use. A single application, sprayed against the baseboard of a room, can nullify odours.

For full particulars write to Turgasept Co. Division of Doho, 100 Varick Street, New York 13, N.Y. or Dohow Chemical Co., Ltd., Montreal 3, Quebec.



THE FRIENDLY, FAMILIAR FACES of "CP" packages help this customer pick the brand that pledges finest quality in every one of its products. Here, a helpful sales clerk passes along a cooking tip in the preparation of Maple Leaf Sausage. Another good reason why his customer looks for the "CP" mark is that she depends on it for purity and freshness.

HOW PACKAGING HELPS TO SET TABLES WITH APPETITE APPEAL



CONVENIENCE in opening and storing any "CP" product is planned by expert package designers. Here, A. J. Tellier and J. S. Brown of the Montreal Plant of Canada Packers, discuss the label for the Domestic Shortening canister with artist-designer Ted Graham.



FRESHNESS AND PURITY of contents is the basic reason for scientific packaging. "CP" standards for this quality are the highest science can set. Here are some of your favourite "CP" packages, specially designed to bring you food at its freshest and purest.

This mark



reminds us to do the smallest things right!

Some of the best things Canada Packers offer you depend on many small jobs that must be done meticulously to give you finest quality.

We make this pledge of finest quality to you, on every product that bears our "CP" mark. And this mark gives us a greater sense of obligation to fulfill our promise.

And we've had some success, we think. For, over the years, we have gained and kept more and more customers and have been privileged to assume much responsibility in the food industry.

Our expansion and growth has enabled us to employ the finest technical and scientific resources for constant improvement of our products—and for development of new products. And, it helps us do the smallest things as well as they can be done.

You put a lot of time and thought into small things, too—like serving your dishes in the most appetizing way. We, too, draw fully on our resources to prepare and package that food attractively and conveniently.

Packaging is just one of the 'small things'—but an important one—that helps you buy with confidence when you are guided by the "CP" mark.



Index of Advertisers

SEPTEMBER, 1958

A		Industrial Textiles Limited	32
A. B. C. Specialty Company	131	Ingram & Bell Limited	4, 13, 57, 114
Abbott Laboratories Limited	99	International Nickel Co. of Canada Limited	135
Agnew and Ludlow	128	J	
Agnew, Peckham & Associates	129	Johns, O. H. Glass Company	104
Air-Shields Canada Limited	8-9	Johnson & Johnson Limited	31, 63
American Cystoscope Makers, Inc.	57	K	
American Sterilizer Co. of Canada Limited	11	Kendall Co. (Canada) Limited	7
Ayers Limited	120	Kitchen Specialties, Inc.	18, 69
B		Kraft Foods Limited	28-29
Bakelite Co., Div. of Union Carbide Canada Limited	103	L	
Banfield, Arnold & Co. Limited	120	Lederle Laboratories	97
Bard, C. R., Inc.	81	Linde Air Products Co., Div. Union Carbide Canada Limited	133
Bard, Parker, Co., Inc.	98	M	
Bassick Div., Stewart Warner Corp. of Canada Limited	109	Marani & Morris	128
Bauer & Black Div., Kendall Co. (Canada) Limited	7	Mathews Conveyor Co. Limited	110
Baxter Laboratories of Canada Limited	4	McKague Chemical Company Limited	127
Becton, Dickinson & Co., Canada, Limited	67	Meals on Wheels System	69
Beiersdorf, P. & Company	71	Moffats Limited	93
Booth, W. E. Company Limited	101	N	
C		National Silicates Limited	108
Canada Packers Limited	139	Nibroc Sales	10
Canadian International Paper Company	10	O	
Canadian Laundry Machinery Co. Limited	II Cover	Organon, Inc.	14
Casgrain & Charbonneau Limited	19-20, 61	P	
Cash, J. & J., Inc.	124	Parke, Davis & Co. Limited	91
Castle, Wilmet Company	19-20	Parker, White & Hayl, Inc.	98
Celotex Corporation	105	Parkin, J. B. Assoc.	129
Chaput, Paul Limited	26	Pharmaseal Laboratories, Inc.	79
Clay-Adams Company, Inc.	77	Philips Electronics Industries Limited	109
Colgate-Palmolive Limited	6	Physicians' Record Company	122
Corbett-Cowley Limited	III Cover	Picker X-Ray Engineering Limited	3
Cow & Gate (Canada) Limited	21	Pioneer Rubber Company	121
Craig, Madill, Abram and Ingleson	128	Professional Tape Company, Inc.	95
Craig and Zeidler	128	Purkett Manufacturing Company	117
Cutter Laboratories	22	Q	
Cyanamid of Canada Limited	17, 75, 97	Quicap Company, Inc., The	110
D		R	
Diversey Corp. (Canada) Limited	115	Royal Victoria Hospital	131
Dominion Glass Company Limited	112	Russell, F. C. Co. of Canada Limited	119
Dominion Oilcloth & Linoleum Co. Limited	125	S	
Dominion Sound Equipments Limited	105	Scholl Mfg. Co. Ltd.	24
Dominion Textile Co. Limited	107	Shell Oil Co. of Canada Limited	88
Down Brothers & Mayer & Phelps Limited	92	Singer's Foods Products Limited	116
Dunlop, Wardell, Mitsui & Aitken	128	Sklar, J. Manufacturing Company	111
Duplan Canada Limited	103	Smith and Nephew Limited	15
DuPont Co. of Canada (1956) Limited	83	Smith, Kline & French	87
Dustbane Products Limited	25	Sommerville, McMurrick & Oxley	129
Dye and Chemical Co. of Canada Limited	124	Sterling Rubber Company Limited	100
E		Sterne Equipment Co. Limited	59
Eatons of Canada	116	Stevens Companies, The	19-20, 123
Electro-Vox Intercom, Inc.	26	Swann, W. R. & Company Limited	113
Everest & Jennings, Inc.	126	T	
F		Taylor, Edward Limited	118
Fair, Leslie R. & Associates	128	Travenol Laboratories, Inc.	4
Fisher & Burpe Limited	30	U	
Fleming & Smith	128	Union Carbide Canada Limited	103, 133
Flex-Straw Corp.	13	United-Carr Fastener Co. of Canada Limited	59
G		V	
General Electric X-Ray Corp. Limited	72-73	Vacuum Can Company	96
Goodyear Tire & Rubber Co. of Canada Limited	27	Vollrath Company	114
Goven, Ferguson, Lindsay, Kaminker, Langley & Keenleyside	128	W	
H		Wabasso Cotton Co. Limited	132
Hardie, G. A. & Co. Limited	106	Walker Croswell & Co. Limited	137
Hartz, J. F. Co. Limited	71, 89	Wilmet Castle Company	19-20
Hollister, Franklin C. Company	102	Wilson, James H. Limited	26
I		Wood, G. H. & Co. Limited	23, 65, IV Cover
Ilford Limited	101	Woods, Chester C.	129
Imperial Surgical Company	16	X	
		X-Ray & Radium Industries Limited	85

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O. R. APPAREL AND ACCESSORIES



SURGEON'S OPERATING GOWN

A full length gown with plain front, standing collar and full length sleeves. Closes down the back with tie tapes, and with long belt stitched on front, to tie at back. Can be furnished with knitted cuffs which fit closely and easily into the rubber gloves. Available in three sizes: small, medium and large.

Style No. 431. Stocked.

**Garments and Accessories
in Colour, White or
Unbleached**

●
**Quotations and
Catalogue on request**

CROSS-TOP OPERATING SUIT

Another one-piece suit requiring no buttons. Featuring cross top, this garment can be easily slipped on without further adjustment. Can be made in bleached, unbleached, or colour.

Style No. 360. Made to order.



STYLE NO. 356

This one-piece garment (no buttons required) is in great demand for surgeons' work. The adjustable tie tape belt and one piece features alone commend its use. Made from best quality bleached suiting.

Stocked in even sizes 34-44



SURGEON'S BONE GOWN

Similar to our style 431 with the addition of a flap which covers tie opening at the back and is held by all-around belt. This feature makes gown more sterile. Can be made in colour, bleached or unbleached materials.

● MASKS

● BINDERS

● ARM BANDS

● STAND COVERS

● SHOE COVERS, etc.

● SECTION SHEETS

● LAPAROTOMY SHEETS

● LITHOTOMY SHEETS

● SPINAL SHEETS

● THYROID SHEETS, etc.

CORBETT-COWLEY

Limited

2738 Dundas Street W., Toronto, 9, Ont. — 426 St. Helene Street, Montreal, 1, Que.

have **CLEAN** paper towels always handy!



Brompton

PAPER TOWELS

So efficient — They eliminate line up or waiting for someone to finish drying. Economical dispensers can be located wherever convenient.

So sanitary — No handling soiled towels—no risk of infection. Brompton towels *touch no one's hands but those of the user.*

So soft — Brompton individual paper towels provide a fast . . . smooth . . . economical drying medium.

So economical — Save money with low cost Brompton paper towels.

Brompton K-20 — These general service Kraft towels have maximum absorbency and are recommended for general washroom use.

Brompton W-20 — These white towels are unsurpassed in quality . . . are lint-free . . . soft . . . very absorbent . . . do not fall apart when wet. They can be used as industrial "white-wipes" to wash, polish or clean up anything.

Made in Canada by
St. Lawrence Corporation
Limited, Montreal,
Que. Mills located at
Dolbeau, East Angus
and Three Rivers, Que.,
Nipigon and Red Rock,
Ontario.

Wood's
SANITATION
FOR THE NATION

Exclusive Distributors

G. H. WOOD & COMPANY LIMITED

MONTREAL TORONTO VANCOUVER • BRANCHES THROUGHOUT CANADA